

Respirator Fit Test Form

Employee: Dollie Roberts SS# 235 190309

Job Function: _____ Location: _____

Type of Respirator: 3M Type of Cartridge/Filter: NIOSH 450-01-01

Fit Test Protocol: _____ NIOSH# 450-01-01

Manufacturer: 3M Model: DIN Size: M

Prerequisites to Fit Test

1. Has the required medical screening been completed? Yes ☒ No ☐ N/A ☐
2. Does the Physical Examination Request form indicate that employee is qualified to wear respirator? Yes ☒ No ☐ N/A ☐
3. Has the Respirator Medical Evaluation Questionnaire been completed and provided to the physician? Yes ☐ No ☐ N/A ☐

Characteristics for Seal

1. Clean Shaven? Yes ☒ No ☐ N/A ☐
2. Facial hair does not interfere with respirator seal? Yes ☐ No ☒ N/A ☐
3. Facial scars do not interfere with respirator seal? Yes ☐ No ☒ N/A ☐
4. Contact lenses are not being worn? Yes ☐ No ☒ N/A ☐
5. Eye glasses do not interfere with respirator seal? Yes ☐ No ☒ N/A ☐
6. Dentures in place? Yes ☐ No ☒ N/A ☐

Employee Acknowledgement

Employee acknowledges the following requirements:

1. Perform a positive/negative fit test each time respirator is donned. Yes ☒ No ☐ N/A ☐
2. Discontinue use of modified, altered or damaged respirators. Yes ☒ No ☐ N/A ☐
3. Assure facial hair, eyeglasses or clothing does not interfere with respirator seal each time it is donned. Yes ☐ No ☒ N/A ☐

Note: A new fit test must be performed in the event of significant weight gain/loss (20 lb.), dental work or any facial change that may affect the seal of the respirator.

Employee PASSED respiratory fit test ☒ Employee FAILED respiratory fit test ☐

Employee Signature: Dollie Roberts

Date: 9-21-26

Test Conducted by: (print) Kristin Harper

Date: 9/21/21

Conductors Signature: Kristin Harper

☐ Mandatory ☒ Discretionary
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Company:

COX

Dr. J Chiropractic & Wellness Center
642 Cross Lanes Drive
Nitro, WV 25143

**Respirator Medical
Evaluation Questionnaire**
Appendix c to 1910.134- OSHA (MANDATORY)

To the Employer: Answers to questions in section 1. Part A, Section 2 does not require a medical examination.

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality your employer or supervisor must not look to review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

To the Employee: Can you read (circle one): YES/NO

PART A. SECTION 1 (Mandatory). The following information must be provided by every employee who must use any type of respirator. (PLEASE PRINT)

1. Today's date: Sep 21
2. Your name: Dollie Roberts
3. Your age (to nearest Year): 48 1
4. Sex (circle one): Male/Female
5. Your height: 5 ft. 3 in.
6. Your weight: 215 lbs.
7. Your job title: Cleaning Tanks
8. A phone number where you can be reached by the health care professional who reviews this questionnaire
(304) 206-0306
9. The best time to contact you at this number: 7am to 5pm
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one)
YES/NO
11. Check the type of respirator you will use (you can check more than one)
a) N.R. or P disposable respirator (filter mask, non-cartridge type only)
b) X Other type (for example, half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
12. Have you worn a respirator? (circle one)
YES/NO
If yes, what type(s): _____

PART A. SECTION 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (please circle YES or NO)

1. Do you currently smoke tobacco, or have you smoked in the last six months? YES/NO ☒ YES
2. Have you ever had any of the following conditions?
 - a) Seizures (fits) YES/NO ☒ YES
 - b) Diabetes (sugar disease) YES/NO ☒ YES
 - c) Allergic reactions that interfere with your breathing YES/NO ☒ YES
 - d) Claustrophobia (fear of closed-in places) YES/NO ☒ YES
 - e) Trouble smelling odors? YES/NO ☒ YES
 - g) Coughing that produces phlegm (thick sputum) YES/NO ☒ YES
 - h) Coughing that wakes you early in the morning YES/NO ☒ YES
 - i) Coughing that occurs mostly when you are lying down YES/NO ☒ YES
 - j) Coughing up blood in the last month YES/NO ☒ YES
 - k) Wheezing YES/NO ☒ YES
 - l) Chest pain when you breathe deeply YES/NO ☒ YES
 - m) Any other symptoms that you think may relate to lung problems YES/NO ☒ YES
3. Have you ever had any of the following pulmonary or lung problems?
 - a) Asbestosis YES/NO ☒ YES
 - b) Asthma YES/NO ☒ YES
 - c) Chronic Bronchitis YES/NO ☒ YES
 - d) Emphysema YES/NO ☒ YES
 - e) Pneumonia YES/NO ☒ YES
 - f) Tuberculosis YES/NO ☒ YES
 - g) Silicosis YES/NO ☒ YES
 - h) Pneumothorax (collapsed lung) YES/NO ☒ YES
 - i) Lung cancer YES/NO ☒ YES
 - j) Broken ribs YES/NO ☒ YES
 - k) Any chest injuries or surgeries YES/NO ☒ YES
 - l) Any other lung problems that you have been told about YES/NO ☒ YES
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
 - a) Shortness of breath YES/NO ☒ YES
 - b) Shortness of breath when walking fast on level ground or walking up a slight hill or incline YES/NO ☒ YES
 - c) Shortness of breath when walking with other people at an ordinary pace on level ground YES/NO ☒ YES
 - d) Have to stop for breath when walking at your own pace on level ground YES/NO ☒ YES
 - e) Shortness of breath when washing or dressing yourself YES/NO ☒ YES
 - f) Shortness of breath that interferes with your job YES/NO ☒ YES
5. Have you ever had any of the following cardiovascular or heart problems?
 - a) Heart attack YES/NO ☒ YES
 - b) Stroke YES/NO ☒ YES
 - c) Angina YES/NO ☒ YES
 - d) Heart failure YES/NO ☒ YES
 - e) Swelling in your legs or feet (not caused by walking) YES/NO ☒ YES
 - f) Heart arrhythmia (heart beating irregularly) YES/NO ☒ YES
 - g) High blood pressure YES/NO ☒ YES
 - h) Any other heart problems that you've been told about YES/NO ☒ YES
6. Have you ever had any of the following cardiovascular or heart symptoms?
 - a) Frequent pain or tightness in your chest YES/NO ☒ YES
 - b) Pain or tightness in your chest during physical activity YES/NO ☒ YES
 - c) Pain or tightness in your chest that interferes with your job YES/NO ☒ YES
 - d) In the past two years have you noticed your heart skipping or missing a beat YES/NO ☒ YES
 - e) Heartburn or indigestion that is not related to eating YES/NO ☒ YES
 - f) Any other symptoms that you think may be related to heart or circulation problems YES/NO ☒ YES

7. Do you currently take medication for any of the following problems?

- a. Breathing or lung problems YES/NO
- b. Heart trouble YES/NO
- c. Blood pressure YES/NO
- d. Seizures YES/NO

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9)

- a. Eye irritation YES/NO
- b. Skin allergies or rashes YES/NO
- c. Anxiety YES/NO
- d. General weakness or fatigue YES/NO
- e. Any other problems that interferes with your use of respirator YES/NO

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

YES/NO

Questions 10-15 must be answered by every employee who has been selected to use either a full-face respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporary or permanently)?

YES/NO

11. Do you currently have any of the following vision problems?

- a. Wear contact lenses YES/NO
- b. Wear glasses YES/NO
- c. Color blind YES/NO
- d. Any other eye problems YES/NO

12. Have you ever had injury to your ears, including a broken ear drum?

YES/NO

13. Do you currently have any of the following hearing problems?

- a. Difficulty hearing YES/NO
- b. Wear a hearing aid YES/NO
- c. Any other hearing problem YES/NO

14. Have you ever had a back injury?

YES/NO

15. Do you currently have any of the following musculoskeletal problems?

- a. Weakness in any of your arms, hands, legs, or feet YES/NO
- b. Back pain YES/NO
- c. Difficulty fully moving your arms and legs YES/NO
- d. Pain or stiffness when you lean forward or backward at the waist YES/NO
- e. Difficulty moving your head up or down YES/NO
- f. Difficulty moving your head side to side YES/NO
- g. Difficulty bending at your knees YES/NO
- h. Difficulty squatting to the ground YES/NO
- i. Difficulty climbing a flight of stairs or a ladder carrying 25 lbs. YES/NO
- j. Any other muscle or skeletal problem that interferes with using a respirator. YES/NO

I hereby certify that the answers set forth above are true and correct to the best of my knowledge and belief.

Signature Dolla Roberto

Date Sep-17-2026

Reviewed By

(Health Care Professional)