TuftsMedicine
Care at Home

Tufts Medicine Care at Home
Medical Clearance / N95 Respirator FIT Test
Annual Assessment

Employee Name: _____

Department: _____

Tasks employee will perform which may result in potential contact with a patient diagnosed, or suspected of COVID or Tuberculosis (TB):

_____

_____

_____

Have you ever had any of the following?	Yes	No
Dizziness, fainting, or seizures	☐	☐
Chest Pain	☐	☐
Palpitations, abnormal heart beat	☐	☐
Heart disease	☐	☐
Shortness of breath	☐	☐
Wheezing or persistent cough	☐	☐
Asthma or other lung diseases	☐	☐
Uncontrolled high blood pressure	☐	☐
Other conditions that might interfere with a respirator use	☐	☐
Previous problems wearing a respirator	☐	☐

I have been provided with education and information about tuberculosis (TB) and COVID-19, including the risk of occupational exposure and the means of reducing these risks. I understand that a repeat fit test is required if I experience any of the following: a weight change of 10% or more, significant dental work, facial hair growth in the sealing area, reconstructive or cosmetic facial surgery, or facial scarring that could affect the respirator seal.

I have received instruction on the proper use, care, and limitations of the respirator. I understand that the respirator is designed to protect against airborne biological hazards such as TB and COVID-19, but it does not protect against chemical exposure. I have been given the opportunity to ask questions regarding TB and COVID-19 exposure risks, and the correct use and limitations of the respirator.

_____

Signature of Employee ***Date***

Employee Name: _____

Medical Clearance:

This employee has been approved to use an N95 respirator:

☐ Without restrictions ☐ With restrictions listed below:

_____

_____

☐ Further evaluation is required ☐ Not approved to use a respirator

Referred to (Name): _____

_____

Nurse Review: _____

Qualitative FIT Test Results

To be completed by a trained Respirator FIT Tester

Test Medium Used: Saccharin

Number of Squeezes: _____

FIT Test Exercises: ***Check only if test is successful***

_____ Normal Breathing
_____ Deep Breathing
_____ Head Side-to-Side
_____ Head Up & Down
_____ Talking
_____ Bending at Waist
_____ Normal Breathing

Overall FIT Test Result: _____ Pass _____ Fail

Respirator Model (*please circle*):

3M 1860 (Small)	3M 1860 (Regular)	3M 8110S (Small)	ProGear 88020 (Regular)
3M 8210 (One Size)	3M 8210 Plus (One Size)	3M 8200 (One Size)	ProGear 88101 (Small)

Reviewed use, care, and FIT check procedures with employee: _____ Yes _____ No

_____

Signature of FIT Tester ***Date:***