Smart Medicine
STONY BROOK
UNIVERSITY HOSPITAL
Expert Care

RESPIRATOR CERTIFICATION

Name:	Date of Birth:
Employee ID:	Job Title:
Department:	Work Phone:

I. RESPIRATOR TYPE AND USE

Reason for Respirator: _____

Type of Respirator(s) to be worn: ☐N95 ☐Half Face Air Purifying with Cartridges or Filters
☐Full Face Air Purifying with Cartridges or Filters ☐Powered Air Purifying Respirator (PAPR)
☐Self-Contained Breathing Apparatus (SCBA) ☐Other_____

Estimate Weight of Respirator(s): _____

Expected Frequency of Use: _____

Expected Duration of Use: ☐Less than 5 hours/week ☐Less than 2 hours/day ☐2 to 4 hours/day
☐Over 4 hours/day ☐Escape Only (no rescue) ☐Emergency Rescue only ☐Other_____

Expected Physical Work Effort: ☐Light Work ☐Moderate Work ☐Heavy Work

Additional Personal Protective Equipment Worn: _____

Work Environment: ☐Temperatures >77°F ☐Humidity >60%RH ☐Other_____

II. MEDICAL CLEARANCE

☐Fit for respirator use with no restrictions
☐Fit for respirator use with mild restrictions or accommodations (see Limitations)
☐Additional testing needed before fitness can be determined
☐Not fit for respirator use

Frequency for Follow up Medical Evaluation: ☐One Year ☐Two Years ☐Other_____

Limitations: _____

_____ _____
Signature of Medical Provider Date

III. TRAINING AND FIT TESTING

The employee was trained in the appropriate use, limitations and maintenance of the following respirator. Employee was fit tested using the following method and passed the fit test.

_____
Type of Respirator(s) - Manufacturer, Model, and Size.

☐ Bitrex – Sensitivity (circle one) 10 20 30 ☐ Saccharin – Sensitivity (circle one) 10 20 30
☐ Portacount - Fit Factor _____ ☐ Other _____

_____ _____
Signature of Trainer/Fit Tester Date

IV. CERTIFICATION

☐ Successfully completed medical clearance, training and fit testing and is certified to wear the respirator(s) issued.
☐ Could not be certified for respirator use (see Comments).

Comments_____

ACKNOWLEDGEMENT - I was issued the above respirator(s) and agree to use in accordance with the facility's Respiratory Protection Program and the manufacturer's instructions.

_____ _____
Signature of Employee Date

DISTRIBUTION: WHITE- EH&S; YELLOW-Employee; PINK-Employee Health