



RESPIRATOR FIT TESTING AND TRAINING ACKNOWLEDGMENT

Name: _____ Position: _____ Facility: _____

Date recommended from LHCP that user may wear a respirator: _____

Explain any limitations: _____

Date of fit test: _____

Conducted by: _____ Position: _____

Respirator type/manufacturer: _____ Model: _____ Size: _____

Type of fit test performed: Qualitative Quantitative (Fit factor score): _____

Results of fit test: Pass Fail - reason for failed test: _____

As the user, I acknowledge that I have reviewed, understand, and agree to follow the procedures and expectations for respirator use per DOC 890.090 Respirator Program and Washington Administrative Code (WAC) 296-842, including the following:

- The employer’s and wearer’s responsibilities.
- The use of a respirator to protect me from exposure to hazardous chemicals and riot control agents, such as Oleoresin Capsicum (OC), CS gas (i.e., tear gas).
- Improper fit, use, or maintenance can compromise the respirator’s effectiveness and reliability.
- How to inspect, clean, disinfect, repair, put on, remove, check the fit, and store the respirator or how to get assistance from someone else.
- Cleaning and inspections must be documented on DOC 03-246 Industrial Respirator Cleaning and Inspection Log.
- I must be clean-shaven in the sealing periphery of the respirator facepiece and will not have facial hairstyles that could interfere with respirator fit, form, or function.
- Operational capabilities and limitations of the respirator, including that air purifying respirators must not be used in oxygen-deficient atmospheres.
- How to use the respirator effectively including what to do when the respirator fails and where respirators are stored.
- Medical signs and symptoms that may limit or prevent the effective use of respirators (e.g., shortness of breath, dizziness).
- While assigned to a position designated as a “Mandatory Use Respirator Position” I must fit test and attend annual training. I understand that I must complete annual training before fit testing can be conducted.

I will complete DOC 03-219 Respirator Medical Evaluation Questionnaire if I have any health status (e.g., weight gain/loss) or any other changes that may impact my ability to wear a respirator and maintain a proper fit. I can contact the Occupational Nurse Consultant to ask clarifying questions and determine if a new questionnaire needs to be completed.

Signature: _____ Date: _____

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14. Upon completion, the data classification category may change.

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