

Occupational Health Services

Respiratory Protection Program- Annual Fit Testing

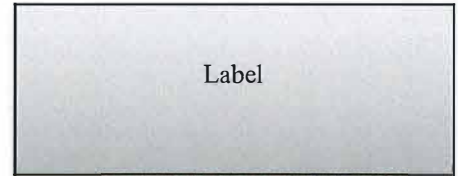
Name: _____ Date: _____



Department: School of Medicine

Job Title: Medical Student (MD/MSPA)

Phone # _____ DOB: _____



PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you had any problems or difficulties using a respirator in the past? Yes No
If YES, please speak with an OHS health care provider.

Employee Signature: _____

This person has passed the QLFT Yes No

Mask: 3M Model: 1860 1860s 1870 +

Others: _____
Make Model

This person needs to complete the Healthstream model for CAPR and return the certification of completion to OHS.

CAPR Training can be requested by emailing: OccHealth@stanfordhealthcare.org

Fit tester signature: _____