



TOWN OF VERNON FIRE DEPARTMENT

P. O. BOX 54
VERNON, CONNECTICUT 06066

TB RESPIRATOR FIT TEST

TEST DATE: _____ EMPLOYEE NUMBER: _____
LAST NAME: _____
FIRST NAME: _____
NOTES: _____

RESPIRATOR
MANUFACTURER: ___ WILSON ___ RACAL ___ HEALTH CARE
TYPE: N9520 DISPOSABLE
MASK STYLE: HALF FACE
MASK SIZE: ___ X-SMALL ___ SMALL ___ MEDIUM ___ LARGE ___ REGULAR
TESTING AGENT: SACCHARIN SOLUTION
TYPE OF TEST: QUALITATIVE-TASTE THRESHOLD SCREENING

<u>EXERCISE</u>	<u>PASS</u>	<u>FAIL</u>
NORMAL BREATHING:	_____	_____
DEEP BREATHING:	_____	_____
HEAD SIDE TO SIDE:	_____	_____
HEAD UP AND DOWN:	_____	_____
TALKING	_____	_____
NORMAL BREATHING	_____	_____
OVERALL RESULT:	_____	_____

TEST CONDUCTED BY: _____

QUALITATIVE TEST: (TASTE THRESHOLD SCREENING)
SACCHARIN IS RELEASED APPROXIMATELY 1 TO 2 INCHES FROM FACE. SACCHARIN PUFFS ARE RELEASED AROUND FACE SEAL AREA AND EXHALATION VALVE WHILE WEARER BREATHES DEEPLY AND TURNS HEAD SIDE TO SIDE AND UP AND DOWN. IF THE SACCHARIN DOES NOT IRRITATE WEARER AT ANY TIME DURING THE TEST, THE TEST RESULT IS SATISFACTORY.
NOTE: IF AT ANYTIME THE SACCHARIN IRRITATES THE WEARER, THE TEST IS TO BE TERMINATED. THE WEARER IS TO BE REFITTED BEFORE RETESTED AGAIN.

I CERTIFY THAT I WAS ADMINISTERED THE QUALITATIVE FIT TEST FOR THE TB RESPIRATOR (S) THAT I WILL BE USING AS A MEMBER OF THE TOWN OF VERNON FIRE DEPARTMENT ON _____ I FURTHER CERTIFY THAT AT NO TIME DURING THE TEST DID I DETECT ANY IRRITATION FROM THE SACCHARIN.

SIGNATURE: _____