Qualitative Fit Test (QLFT) Form

Employee Name	Date of Birth (Year)	Height	Weight
Work Unit	Supervisor Name		

A respirator fit test must be completed by an individual trained in respiratory fit testing procedures. **This fit test is required annually.**

Does employee wear glasses? _____ Yes _____ No
Does Employee have facial hair, dentures or other attributes that will prevent a positive face fit? _____ Yes _____ No

Respirator Type (Make Model and Certification Number)			
Testing media			
Compatible with eye glasses	____Yes____No	____Yes____No	____Yes ____No
Positive pressure fit check	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Negative pressure fit check	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Head Stationary Normal Breathing (60 seconds)	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Head Stationary Deep Breathing (60 seconds)	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Head Turning Side To Side (60 seconds)	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Head Moving Up and Down (60 seconds)	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Talking (recite Rainbow Passage or count backwards)	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Bending Over (60 seconds)	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Head Stationary Normal Breathing (60 seconds)	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail
Respirator fit test result	___Pass ___Fail	___Pass ___Fail	___Pass ___Fail

Based on information provided on this form, I certify that the employee named on this form can wear the respiratory protective equipment listed above.

Signature of Person Administering Test _____ Date _____