New Jersey Department of Health
PEOSH Unit

FIT-TEST RECORD

[Responder has been medically cleared to wear a respirator prior to fit-testing.]

Name of EMS Agency
Name of EMS Responder
Date of Fit-Test
Type of Fit-Test *(Check)* ☐ Qualitative OR ☐ Quantitative ☐ Bitrex List device used: ☐ Saccharin _____ _____

Respirator Model:
NIOSH
Size:
PASS/FAIL:
Fit Factor:
Brand #:
Approval #:

Name of Person Conducting Test
Title