



**Postgraduate Medical Education
Mask Fit Accommodation Form
Residents, Clinical Fellows, and Elective Learners**

Please submit this form to the [Registration Document Portal](#).

Last Name: _____ **First Name:** _____ **Trainee No.:** _____

I am aware that I am not Mask Fit tested and will not be permitted to participate in any rotation/training that requires the use of N95/Respirator masks in the hospital or community setting, for the following reason:

☐ Religious/Cultural

☐ Medical Condition

☐ Other (please specify): _____

If for any reason I am exposed to airborne infectious agents, I will seek immediate medical attention and report the incident to my Program Director and the Occupational Health Office of the hospital/ training site of my current rotation.

In light of the COVID-19 pandemic, I understand that I am not to participate in any clinical rotations or be present in any hospital setting that may expose me to any airborne contaminants.

If there is any change to my status, I will notify my Program Director and the Postgraduate Medical Education Office to update the status of my mask fit exemption.

I understand that this Mask Fit accommodation form is valid for 2 years from the date all signatures are provided on this form and must be renewed for the accommodation to remain valid. I understand that if I am completing an elective this Mask Fit accommodation form is only valid for the duration of the elective.

Learner Signature

Date

Occupational Health Office Signature/Stamp
(acknowledging inability to mask fit)

Date

Program Director Signature

Date