Postgraduate Medical Education
UNIVERSITY OF TORONTO

Temerty Medicine

Postgraduate Medical Education
Respirator/Mask Fit Form
Residents, Clinical Fellows, and Elective Learners

Please bring this form with you when you get tested at the Occupational Health Office.

Please submit this form to the Registration Document Portal.

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

Instructions:

- All medical learners must provide PGME with at least one valid respirator-fit data.
- **Respirator/mask fit tests are valid for 2 years** as per PGME Respiratory Protection Policy and learners must be re-tested to remain registered as facial characteristics can change due to weight gain/loss or facial trauma.
- Please complete this form or forward your mask fit card to the PGME office (stickers on ID badges are not accepted).
- New learners training for 1 year or more do **not** require mask fit for registration, it should be completed during your first rotation at your training sites Occupational Health Office. This will ensure you are fitted for a mask your hospital carries.
- New learners training for under 1 year must submit their mask fit information prior to starting training.
- Returning learners, mask fit testing must be renewed and submitted prior to the expiration of your previous mask fit.
- Only 3M and Kimberly Clark masks will be accepted by PGME. Halyard, Molodex, and Duck Bill will not be accepted.

RESPIRATOR/MASK FIT DATA:

Date Fitted: _____ **Brand:** _____ **Type/Size:** _____
(DD/MM/YYYY)

Hospital/Site of Fit Test: _____

Comments: _____

Learner Authorization: I certify that the above information is complete and accurate. I give my consent that the information on this form may be shared with university/hospital teaching and administrative staff in appropriate cases.

Signature of Resident/Clinical Fellow: _____ **Date:** _____

Clinic/Health Centre Authorization: I certify that the above information is complete and accurate. I give my consent that the information on this form may be shared with university/hospital teaching and administrative staff in appropriate cases.

_____
(Name, address, and phone number of centre where form was completed)

Signature of Health Care Professional: _____ **Date:** _____
(Health Care Professional signature is mandatory – not yourself)