Please bring this form with you when you get retested as Occupational Health Offices does not provide them for learners.

Please submit this form to the PGME portal:
https://forms.pgme.utoronto.ca/?f=PGME_Document_Submission_Form

Last Name: ___________________________ First Name: ___________________________ Student No. ___________________________

Instructions:
• All medical learners must provide PGME with at least one valid respirator-fit data.
• Respirator/mask fit data are valid for 2 years as per PGME Respiratory Protection Policy and trainees must be re-tested to remain registered as facial characteristics change due to weight gain/loss or facial trauma.
• Please complete this form or forward copies of your respirator/mask fit cards to PGME office (stickers on ID badges are not accepted).
• Initial mask fit testing can be obtained at the hospital of your first rotation and at your current hospital site for residents and fellows training over 1 year.
• Electives and fellows training for under 1 year must submit their mask fit information prior to starting training.
• Renewal mask fit testing must be submitted prior to the expiration of the previous mask fit test.
• 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)

Quality of Fit: ___________________________ Expiration Date: ___________________________
(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/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: ___________________________