



**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 [PGME Forms Site](#).

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)