

## Qualitative Fit Test (QLFT) Form

Employee Name	Date of Birth (Year)	Height	Weight
Work Unit	Supervisor Name		

A respirator fit test must be completed by an individual trained in respiratory fit testing procedures. **This fit test is required annually.**

Does employee wear glasses? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does Employee have facial hair, dentures or other attributes that will prevent a positive face fit? \_\_\_\_\_ Yes \_\_\_\_\_ No

Respirator Type (Make Model and Certification Number)			
Testing media			
Compatible with eye glasses	Yes No	Yes No	Yes No
Positive pressure fit check	Pass Fail	Pass Fail	Pass Fail
Negative pressure fit check	Pass Fail	Pass Fail	Pass Fail
Head Stationary Normal Breathing (60 seconds)	___ Pass ___ Fail	___ Pass ___ Fail	___ Pass ___ Fail
Head Stationary Deep Breathing (60 seconds)	___ Pass ___ Fail	___ Pass ___ Fail	___ Pass ___ Fail
Head Turning Side To Side (60 seconds)	___ Pass ___ Fail	___ Pass ___ Fail	___ Pass ___ Fail
Head Moving Up and Down (60 seconds)	___ Pass ___ Fail	___ Pass ___ Fail	___ Pass ___ Fail
Talking (recite Rainbow Passage or count backwards)	___ Pass ___ Fail	___ Pass ___ Fail	___ Pass ___ Fail
Bending Over (60 seconds)	Pass Fail	Pass Fail	Pass Fail
Head Stationary Normal Breathing (60 seconds)	___ Pass ___ Fail	___ Pass ___ Fail	___ Pass ___ Fail
Respirator fit test result	Pass Fail	Pass Fail	Pass Fail

Based on information provided on this form, I certify that the employee named on this form can wear the respiratory protective equipment listed above.

Signature of Person Administering Test \_\_\_\_\_ Date \_\_\_\_\_



Infectious Disease Epidemiology, Prevention and Control  
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If you require this document in another format, such as large print, please call 612-676-5414.