Compliance by Synergy Gateway

Qualitative Respirator Mask Fit Testing Assessment Form

Part 1: Personal Information (Please PRINT IN INK BLOCK LETTERS Clearly) * = Required Fields

This confidential form is prepared in compliance with C.S.A Standard Z94. 4-11, and in conjunction with Synergy Gateway Inc. Privacy and Confidentiality policies. Health information collected on this form is NOT shared with any party outside of those granted consent as outlined in this form, or disseminated in any way, and is used to determine eligibility for qualitative respiratory mask fit testing.

*First Name:		*Last Name:	
Title / Occupation/ Program:		Employee ID / Student ID	
*Organization / School:		Email	

Used for expiration reminders and other services notifications only.

Part 2: Respirator Mask User's Health Conditions

***A.** Some symptoms/conditions can affect your ability to safely use a respirator. Do you currently experience any of the following conditions that are in an **UNSTABLE STATE** **(not controlled under the direction of a physician)** that may affect respirator mask use? **(Circle all that apply)**

Shortness of Breath	**COPD/Emphysema**	**Uncontrolled Hypertension**
Chest pain on exertion	**Coronary Artery Disease / Angina**	**Asthma**
Dizziness/Nausea	**Claustrophobia**	**Myasthenia Gravis**
Severe Allergic Rhinitis	**Latex Allergies**	

Other condition(s) affecting respirator mask use: _____

***B. Any previous health concerns while using a respirator mask (ie. skin irritation)?** ☐ **Yes** ☐ **No**

***C. Do you have trouble tasting bitter?** ☐ **Yes** ☐ **No**

***D. Have you ever had a severe allergic reaction to anything that required treatment?** ☐ **Yes** ☐ **No**
If "YES" to "D", what did you react to and what were the symptoms?

_____

***E. Have you ever used or been prescribed an EPI pen?** ☐ Yes ☐ No

***F. Do you have your EPI pen with you?** ☐ Yes ☐ No

***G. Do you have any of the following that will interfere with respirator use:** (only check if you have any of these)
☐ Facial Hair ☐ Facial Injury ☐ Facial Piercing

H. If you are pregnant, we strongly advise you seek medical advice prior to participating in this program.

If you checked off any conditions in **PART "A"** or answered **"YES" to ANY OF THE ABOVE** we recommend an assessment by a healthcare professional prior to conducting a Qualitative Respirator Mask Fit Test. **NOTE:** Medical information is **NOT** offered on this form.

Disclaimer:
information collected is in accordance with our privacy and confidentiality and electronic records policies. The health information collected on this form is **not** revealed to any party or employer. The results of your fit test may be required by your employer and/or educational institution, IN WHICH CASE YOU AUTHORIZE SYNERGY GATEWAY INC. TO FORWARD RESULT INFORMATION limited to: name, date of completion, mask make(s), mask model(s), solution, organization and status. Your information is collected for verification and test QUALIFICATION, expiration reminders and notification of other services available to you by us only. We do not share you personal health information. You hereby give Synergy Gateway Inc. CONSENT TO HAVE YOUR QUALITATIVE RESPIRATOR MASK FIT TESTING COMPLETED on the date noted below.

_____ _____
Participant Signature **DATE**

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