Respirator Request Form

TM Name: ____ DOB:___________________

Email Address: ___________________________________Phone #:__________________________________

Entity: _____________________________________ Department: ___________________________________

Job Title: ____________________________________Leader: _____________________________________

Respirator Type

Make:_________________________ Model: ________________________ Date of purchase: ___________

TC #: ____

Type of filter: ☐N95 ☐P95 ☐N100 ☐P100

Provider Determination

☐Respirator verified as NIOSH approved

☐Respirator filter approved for use in healthcare setting

☐Respirator inspected today and determined to be acceptable for use

☐Respirator approved for use ☐Respirator NOT approved for use

Notes:

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TM is responsible for wiping down respirator using appropriate disinfectant following each doffing. TM responsible for changing cartridges, cleaning, disinfecting and storing respirator as per manufacturer's instructions. TM must be fit-tested by Occupational Health prior to using respirator. Leader will coordinate competency training.

TM signature: ____ Date: ______________________

TM Name: ____

Provider Signature: ____ Date: ______________________

Provider Name: ____