

Respiratory Protection Exemption Form

First Name: _____ Last Name: _____

ID: _____ Dept /Program: _____

HHS Role: **Staff** **Student** **Physician** **Affiliate**

I am aware that I am not mask fit tested and will not be permitted to participate in providing care to any patient or participating in any rotation/training that requires the use of N95/Respirator masks including entry into any Airborne Isolation Area in the hospital or community setting, for the following reason:

- Religious/ Cultural
- Medical Condition
- Other: please specify _____

If for any reason I am exposed to airborne infectious agents, I will seek immediate medical attention and report the incident to direct my direct supervisor and will submit a safety occurrence report.

In the event of a pandemic, I understand that I am not to participate in any clinical rotations or be present in any hospital setting that may expose me to any airborne contaminants.

If there is any change to my status, I will inform my supervisor or Chief of Practice and Health Safety and Wellness to update the status of my mask fit exemption. This exemption will expire in 2 years, but may be renewed if the circumstances requiring the exemption remain unchanged.

Staff Signature Date

Supervisor Signature Position Date

Once Completed Please send a signed copy to Fittest@hpsc.ca