

FORM I

RESPIRATOR USE RECORD

Employee: _

Social Security No.: _

Building Name/No.: _

_Room No.: ____

Supervisor Name: _

Supervisor Title:

Date:

__Phone No.: _

Operation requiring respirator: __

Type of respirator(s) used (circle):

Positive Pressure Device

Negative Pressure Device

SCBA

Half Face Air Purifying

Supplied Air Line

Full Face Air Purifying

Combination Air Line/SCBA

Powered Air Purifying Respirator

Level of Work Effort (circle):

Light

Moderate

Strenuous

Heavy

Length of work effort (estimated in hours): _

Extent of Usage (circle):

Daily

Weekly

Monthly

Emergency Use Only

Form completed by: _

Employee Signature:

cc: Dept. File
Environmental Health and Safety