

New York City Department of Environmental Protection
Asbestos Control Program
59-17 Junction Boulevard, 8th Floor
Flushing, New York 11373

Application for Asbestos Investigator

Appendix B

Respiratory Fit Test

Applicant Name: _____ Date of Birth: _____

Home Address: _____ Telephone Number: (____) ____ - _____

City, State and Zip Code: _____ Social Security Number: ____ - ____ - _____

Training Entity Name:* _____ Telephone Number: (____) ____ - _____

Training Entity Address: _____ City, State, Zip: _____

Specify Type of Test and Test Agent (Mark the appropriate boxes)

Qualitative

- Irritant Smoke Test
- Odor Vapor Test
- Taste Test

Quantitative

- Aerosol
- Gas
- Vapor
- Other _____

Respirators Tested

Type: _____

Brand: _____

Size: _____

Proper Fit:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

Test Administered By:

Print Name of IH, CSP, or CIH**

Date

Signature of IH, CSP, or CIH

Address

Telephone Number

City, State and Zip Code

* If Applicable

** Industrial Hygienist (IH), Certified Safety Professional (CSP) or Certified Industrial Hygienist (CIH)