Do you currently suffer from any of the following which could affect your ability to safely undergo this test?

	Circle indicate
Respiratory Problems (e.g. Asthma)	Yes / No
Neck, Back or shoulder pain	Yes / No
Heart Disease	Yes / No
Angina	Yes / No
High/Low Blood Pressure	Yes / No
Viral infection (Severe cold or flu)	Yes / No
Panic Attacks	Yes / No
Claustrophobia	Yes / No
Are you a smoker	Yes / No
Have you eaten, smoked or drunk (apart from water in the past 20 mins	Yes / No

If you are unsure as to your ability to undertake this test please mention this to the test operator now.

I have no knowledge of any health or other condition that would put my health or the safety of others at risk during this test.

Print name: ……..

Date of Birth: ……

Signature: ……

Company name: ……

Date: ……

The result of this test is applicable only to the person concerned at the time of the test wearing the respirator stated on the test certificate. The test should be repeated in line with your employer's health and safety policy (Minimum Annually).