Methodist Annual Mask Fit Release and Waiver

I, ____________________________________, employee ID# ______________ ("Releasor"), do hereby and voluntarily request to forfeit the N95 proper mask fit process.

I understand and attest that my current position with Methodist does not currently require me to enter areas within the health system where an N95 mask is required.

If my employment circumstances change and I am required to enter areas requiring an N95 mask, I understand that it is my responsibility to contact my immediate supervisor in order to follow the process of being properly fitted for an N95 mask. I further understand that I may also communicate directly with Methodist Employee Health for a proper N95 mask fitting.

If my position with Methodist DOES require an N95 be worn, I understand the proper N95 fit is neither possible nor effective with full facial hair. Instead, if required for my duties, I will wear a PAPR/CAPR. In this scenario, the N95 mask fitting process will not need to occur. However, if at any time a PAPR/CAPR is not available, per OSHA requirements, I may be asked to shave enough facial hair to be properly fitted for, and wear an N95.

It is understood and agreed that I fully understand the consequences of not wearing an N95, and that not wearing an N95 is an elective and voluntary decision made by me.

I further state this Release and Waiver is elective and voluntarily entered into by me, and that I hereby, for myself, my heirs, executors and administrators, fully waive and release all rights and claims that I may have against Methodist, its subsidiaries, employees, directors and officers, for any and all injuries (personal or bodily) now known, or which may become known in the future, for my decision to not wear an N95 mask. I understand that, by signing this document, I attest that I have had any questions I may have regarding N95 mask fittings, as well as the terms and conditions of this Release and Waiver, answered to my satisfaction, and I am voluntarily choosing to sign.

______________________________	____________	______________________________
Releasor's Signature	Date	Releasor's Printed Name
______________________________	____________	______________________________
Releasor's Supervisors Signature	Date	Releasor's Supervisor Printed Name

Return completed form to Employee Health