



FAX TRANSMITTAL SUMMARY

DATE: 2/24/14

TO: Carlin Scholtz

FROM: Adrienne Fluharty, MD

Receiver's Phone # \_\_\_\_\_

Receiver's Fax # 1-303-736-1761

Sender's Phone # 610.326.2300

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Number of Pages (Including this form): 5

Physical Exam Clearance  Company Clearance Forms \_\_\_\_\_ Respirator Clearance

Hearing Test  Vision Test  PPD Skin Test \_\_\_\_\_ Respirator Fit Test \_\_\_\_\_

Drug Screen Result \_\_\_\_\_ Breath Alcohol \_\_\_\_\_ Laboratory Tests \_\_\_\_\_ Chest X-Ray Report \_\_\_\_\_

Physical Abilities Test \_\_\_\_\_

Comments RE: Christian Triglia

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(Sending facility name)



Exam Clearance Report

Examination Date: 03/23/2016

Patient Name: Christian J. Triglia

DOB: 07/10/1992

Company: CMG/Corp Management Group

Contact Person: Caitlin Scholl, Administrative Assist

Ph: 1-303-920-1425

Fax: 1-303-736-7767

The results of the physical examination performed at Occupational Health are as follows:

capable of performing the essential functions of the job.

capable of performing the essential functions of the job with the following accommodations: \_\_\_\_\_

NOT capable of performing the essential functions of the job.

Drug Screen Results: N/A

Negative Rapid Drug Screen

Negative MRO Drug Screen

Positive MRO Drug Screen

Invalid Drug Test

Collection Only- No results available

Physical Therapy/Lifting Test results: N/A

Met physical requirements of \_\_\_\_\_ job demand level.

Did NOT meet physical requirements of \_\_\_\_\_ job demand level.

Comments: \_\_\_\_\_

Examiner: Deborah Bukey CRNP

Reviewer: Denise Edwards 03/24/2016 9:35:01 AM

date: 03/24/2016  
09:35 AM

Christian Triglia

CMG at Lake Region Medical

900-01-5463



Occupational Health  
of Pottstown Memorial Medical Center

Triglia, Christian  
Age: 23 D.O.B.: 07/10/1992  
CMG/Corp Management Group  
Contact: Caitlin Scholl, Admin Assist 303-920-1425  
Appt: 03/23/2016 14:30 DBUKEY

**REQUEST FOR MEDICAL CLEARANCE FOR RESPIRATOR USE**

Name: \_\_\_\_\_ Patient I.D. #: NO SOC #  
Date of Birth: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Employer: \*CMG at Lake Region Medical Dept: \_\_\_\_\_

**Circle Type(s) of NIOSH certified Respirator(s) to be used:**

- |                                 |                            |
|---------------------------------|----------------------------|
| Atmosphere-supplying respirator | Continuous-flow respirator |
| Open-circuit SCBA               | Closed circuit SCBA        |
| Supplied-air respirator         | Air-purifying (powered)    |
| <u>Air-purifying</u>            |                            |

**Level of Work Effort (circle one):**  
Light Moderate Heavy Strenuous

**Extent of Usage (circle one):**  
Daily Basis  
Occasionally-but more than once per week  
Rarely-or for emergency situations only

**Respirator Use is circle one):** Voluntary / OSHA mandated

**Special Work Considerations (circle one):**

- HazMat Team
- Working in High Places
- Extreme Temperature, ie. cold or hot
- Hazardous Materials
- Protective Clothing, ie. boots, gloves, protective suit, safety glasses, face shield, other: \_\_\_\_\_

**Length of time of Anticipated Effort**  
Approximate Hours: < 4hrs

As your occupational health medical provider we need to insure that your respiratory protection program is complete per OSHA guidelines before a respiratory clearance will be given.

As safety representative I certify that:

- My company has a written OSHA respiratory protection program and the program is supervised by an individual knowledgeable of OSHA's Respiratory Protection Regulations
- Employees wear NIOSH certified respirators
- Employees are trained before wearing the respirator and annually thereafter per OSHA's regulations for respirator training
- Respirators are inspected, cleaned/disinfected, and stored per OSHA regulations
- Employees are fit tested after they are medically cleared to wear a respirator and on an annual basis thereafter per OSHA's fit testing regulations (fit testing is not required for "voluntary" respirator use, If OSHA requires a respirator they must be fit tested annually)
- Employees will be medically evaluated on an annual basis (respirator clearance) by a medical provider due to the health risks associated with respirator use when employees health is compromised (Risk factors can change year to year)
- This document will be kept on file by my company per OSHA's recordkeeping regulations

Safety Representative: [Signature] Date: 6/17/2016

No restriction on respirator use  
 Some specific use restrictions ..... Company notified via phone by \_\_\_\_\_ date: \_\_\_\_\_  
 No respirator use permitted ..... Company notified via phone by \_\_\_\_\_ date: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Examining Physician: [Signature] Review Date: 3/23/16

# Audiometric Exam

Name: Christian J. Triglia	Maiden/Previous Name:
Patient ID: 900-01-5463	DOB: 07/10/1992
Company: CMG/Corp Management Group	Dept: Job:

**Patient Completes this Section**

	Yes	No
1. Have you been exposed to loud noises in the last 14 hours without hearing protection?*	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Do you have a cold today?***	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Have you ever been told or noticed that you are hard of hearing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Do you have ringing or buzzing in your ears?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Do you have a history of ear infections or surgery to your ears?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Do you normally use hearing protection at work? If so, what kind? Plugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. History: Please list below any past exposure to noise including military, jobs, hobbies or activities and indicate whether you used hearing protection during these activities: Past and Present Noisy Hobbies: Hunting, Target Shooting, Loud Music, Power Tools, Chain Saw, Lawn Mower.		

\* If yes to 1, baseline audiogram must not be performed today      \*\* If yes to 2, it is suggested the audiogram be postponed

**Examiner/Staff completes this section**

	Yes	No
1. Are ear canals obstructed?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Any other abnormalities noted? If yes, comment: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>

	500	1000	2000	3000	4000	6000	8000
Date: 03/23/2016 Time: 2:30 PM	Right	10	05	00	05	05	05
	Left	15	05	05	00	05	00

[ ] 1K Verification reading

Audiometer # and Calibration Date 38379      07/30/2015      Performed at careplex

**Comments**

Debra Burkey CRNP      3/23/2016 2:30:32 PM

## VISION EXAM

Name: Christian J. Triglia	Patient ID: 900-01-5463	DOB: 07/10/1992
Company: CMG/Corp Management Group Dept:		Job:

UNCORRECTED	Right Eye	Left Eye	Both
Near Vision	20/	20/	20/
Far Vision	20/ 50	20/ 40	20/ 25
CORRECTED	Right Eye	Left Eye	Both
Near Vision	20/	20/	20/
Far Vision	20/	20/	20/

	Right Eye		Left Eye	
Peripheral (degrees)	Nasal	Lateral	Nasal	Lateral

	Acceptable		Comment
	Y/N		
Color			
Depth			
Fusion			

Additional Comments

  
  
  

*Deborah B. Buehler CRNP* 3/23/2016 2:00:20 PM

Examined by: Arlene DeOrnellas, MA. Date: 03/23/2016

