



HealthONE Occupational Medicine/Rehabilitation at North Suburban

9195 Grant Street, Suite 100
Thornton, CO 80229

FAX COVER SHEET

Date: ___/___/___

Time: _____ AM / PM

To:

Corporate Management Group

Fax: 303-736-7767

Fax: _____

From: _____

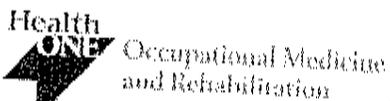
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HEARING TEST FORM

Employee Identification

Last Name <u>Fer</u>	First Name <u>Dawson</u>	Middle Name <u>L</u>	Employee ID#
Plant <u>BASF</u>	Dept/Code	Job/Code	Work Shift Shift Length

If a microprocessor audiometer is used, please indicate the model and serial number.

Audiometric Information

Test Date: 12/15/15
 Test Time: 12:28:00

Test Type: Baseline Annual/Periodic Retest Rehire Exit

Audiometer Make/Model: Tremetrics RAS500 Last Annual Calibration Date: 11/2/15

OSHA sound room requirements met? Yes No

Technician: R. Brena Technician:

Testing Company: HCA

Employee Noise Exposure

High noise exposure within 14 hours: Yes No Last noise exposure: _____ hours ago

Hearing protection used before test: Yes No TWA: Sound Level:

Hearing Protection Devices

- Type Used Specify Model/Size
- Foam plug
 - Pre-molded plug
 - Custom plug
 - Earmuff
 - Plug & Muff
 - Electronic
 - Other

Otososcopic Screening

Left	Right
<input type="checkbox"/>	<input type="checkbox"/>

Hearing Protection fit Check: Proper Poor Re-instructed Replaced

Test Comments:

Employee Training:

- The following topics have been explained to me:
- The effects of noise on hearing
 - The purpose of the hearing test & explanation of procedures
 - Hearing protection use, care, fit and advantages/disadvantages

Employee Signature:

Date: 12/15/2015

OCC HEALTH

DATE: 12/15/15
 TIME: 13:28:53

PATIENT: 1546

CURRENT AUDIOGRAM

FREQ.	L/DB	R/DB
1000 HZ	05	00
500 HZ	00	00
1000 HZ	00	00
2000 HZ	00	00
3000 HZ	00	00
4000 HZ	00	00
6000 HZ	00	00
8000 HZ	00	00
AVG 2,3,4	-000.0	-000.0

TEST ID: 3582315121515380

ELAPSED TIME = 02:25

TEST TYPE = BASILINE
 TEST MODE = CONTINUOUS
 M = MANUALLY TESTED FREQ

TREMETRICS RAS500+

SERIAL NUMBER... 12115380
 SOFTWARE REV. 2.19H-0102
 CALIBRATION: 01/08/14
 CAL. ANSI S3.6 1989

PATIENT: 1546

x D. Fer

EXAMINER:

x R. Brena

QUESTION ANSWERS

LAST NAME:

FIRST NAME:

DOB:

SEX:

JOB TYPE:

LOCATION:

PROTECTION:

EXPOSURE:

BC009.019 - Diisocyanates Medical Surveillance - Health Professionals
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Attachment 1

BASF Corporation
Isocyanates Medical Surveillance - Health Professional

Respiratory Symptom Questionnaire

12/15/2015
Date of Examination

Devin Flier
Employee's Name (Print)

thorton
Location

304-17-1540
Employee's Social Security Number

Please check the single best answer to each question

During the past four weeks:

- | | Yes | No |
|--|--------------------------|-------------------------------------|
| 1.1. Has your chest felt tight or your breathing become difficult? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.2. Has your chest sounded wheezing or whistling? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.3. Have you had a persistent or regular cough? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.4. Have you developed a new skin rash? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If yes to any of the above, please answer the following questions:

- 2.1 If you run, or climb stairs fast do you
- | | | |
|--------------------------------|--------------------------|-------------------------------------|
| 2.1.1. cough? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.1.2. wheeze? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.1.3. get tight in the chest? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- 2.2 Is your sleep broken by
- | | | |
|-----------------------------------|--------------------------|-------------------------------------|
| 2.2.1. wheeze? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.2.2. difficulty with breathing? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- 2.3 Do you wake up in the morning (or from sleep, if a shift worker) with
- | | | |
|-----------------------------------|--------------------------|-------------------------------------|
| 2.3.1. wheeze? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.3.2. difficulty with breathing? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- 2.4 Do you wheeze
- | | | |
|--|--------------------------|-------------------------------------|
| 2.4.1. if you are in a smoky room? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.4.2. if you are in a very dusty place? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- 3.1 What happens to this on weekends?
 better same worse
- 3.2 What happens to this on holidays of 4 days or more?
 better same worse
- 3.3 Does this occur with exposure to a particular substance or process? Please describe.

[Signature] 12-15-15