

Occupational Health

of Pottstown Memorial Medical Center

FAX TRANSMITTAL SUMMARY

DATE: 4/20/16

TO: Caitlin Scholl

FROM: Adriene Hubert

Receiver's Phone # _____

Receiver's Fax # 1-303-736-7767

Sender's Phone # 610.326.2300

Sender's Fax # 610.970.5889

Number of Pages (Including this form): 7

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 _____ Drug Screen Result on Physical Exam Clearance Form _____

Comments RE: David Salem

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I, _____, verify I have received _____
(# of pages, including this form)

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Exam Clearance Report

Examination Date: 04/18/2016

Patient Name: David M. Salem
DOB: 08/04/1982

Company: CMG/Corp Management Group

Contact Person: Caitin 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: James Stephenson, MD Reviewer: Amirah Siddiqui, EdL date: 04/20/2016
13:17 PM

CMG at Lake Region Medical



Occupational Health
of Pottstown Memorial Medical Center

Salem, David

900-01-5937

Age: 33 D.O.B.: 08/04/1982
CMG/Corp Management Group

Contact: Caitlin Scholl, Admin Assist: 303-920-1425
Appt: 04/18/2016 09:30 JSTEPHEN

REQUEST FOR MEDICAL CLEARANCE FOR RESPIRATOR USE

Name: _____ Patient ID # _____ 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

Length of time of Anticipated Effort

Approximate Hours: < 4hrs

Protective Clothing, ie. boots, gloves, protective suit, safety glasses, face shield, other: _____

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

Date

01/17/2016

- 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

Review Date

04/18/16

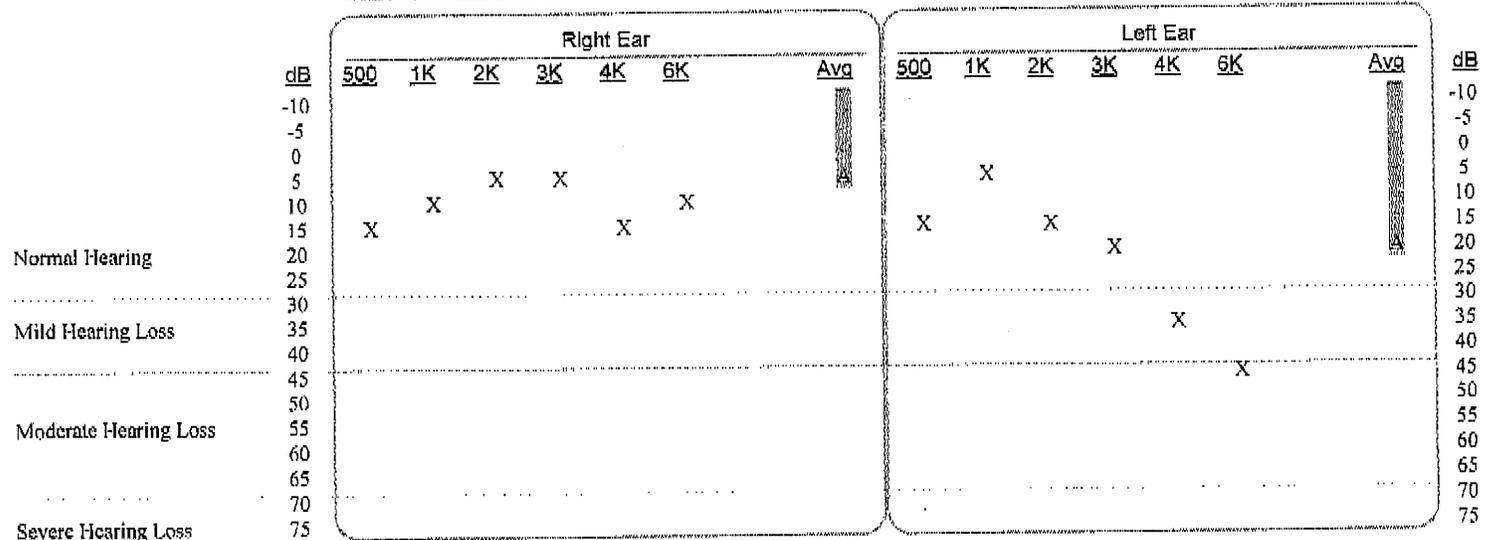
Audiogram Analysis Report

Patient ID: 900-01-5937
 Name: David M. Salem
 Address: 1299 Douglass Drive
 Boyertown, PA 19512
 Home Phone: 215-239-7000
 Work Phone: 303-920-1425

Serial #: 38379
 Calibrated: 07/30/2015
 Tester:
 Summary: Initial Exam
 Current Baseline

Company: CMG/Corp Management Group

Date Type	Date	Right Ear						Left Ear							
		500	1K	2K	3K	4K	6K	Avg	500	1K	2K	3K	4K	6K	Avg
Initial Exam	04/18/2016	15	10	5	5	15	10	8.33	15	5	15	20	35	45	23.33



Interpretation: **Abnormal.**
 Right Ear: Normal.
 Left Ear: **Hearing loss present.**
 STS Analysis: This is an initial exam. This exam is the current Standard Threshold Shift baseline for right ear. This exam is the current Standard Threshold Shift baseline for left ear.

4/20/2016
 Signature: *Carl Burnett, DO*

Audiometric Exam

Name: David M. Salem	Maiden/Previous Name:
Patient ID: 900-01-5937	DOB: 08/04/1982
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 checked="" type="checkbox"/> | <input 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 checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you normally use hearing protection at work? If so, what kind? | <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 Noise Exposure: Hunting, Target Shooting, Power Tools and Machinery | | |

* 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If yes, comment: _____ | | |

	500	1000	2000	3000	4000	6000	8000	
Date: 04/18/2016 Time: 9:30 AM	Right	15	10	5	5	15	10	5
	Left	15	5	15	20	35	45	25

1K Verification reading

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

Comments: Left mild high frequency loss, ear infections & PE tubes as child

 4/18/2016 10:44:13 AM

Examined by: _____ Date: _____

VISION EXAM

Name: David M. Salem	Patient ID: 900-01-5937	DOB: 08/04/1982
Company: CMG/Corp Management Grou Dept:	Job:	

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

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

	Acceptable	
	Y/N	Comment
Color		
Depth		
Fusion		

Additional Comments

Noted



4/18/2016 10:42:30 AM

Examined by: Ianna Rementer, RT Date: 04/18/2016

Pulmonary Function Report

Screener Report

Occupational Health/PMMC
Pottstown, PA

Patient Information		
Name: Salem, David	ID: 900-01-5937	Birthdate: 8/4/1982
Height at test (in): 72.0	Sex: Male	Smoking history (pk-yrs): 1
Weight at test (lb): 286.0	Age at test: 33	Predicted set: Hankinson (NHANES III)

Comments: Quit smoking 2015

Diagnosis:

Interpretation
NORMAL SPIROMETRIC VALUES indicate the absence of any significant degree of obstructive pulmonary impairment and/or restrictive ventilatory defect. This interpretation is valid only upon physician review and signature.

Site: KoKo994861
Physician: Dr. Stephenson
Technician: JAM

Effort protocol: ATS/ERS 2005
Nose clip:
Position:

Test date/time: 04/18/16 09:48:07 AM
Number of efforts performed: 3
Estimated Lung Age: 54

Results	Pred	Best	%Prd	%Prd	%Prd
FVC (L)	5.77	5.15	89%	4.99 86%	4.91 85%
FEV1 (L)	4.65	4.07	88%	3.94 85%	3.81 82%
FEV1/FVC	0.81	0.79	97%	0.79 97%	0.78 95%
FEF25-75% (L/s)	4.51	3.67	81%	3.69 82%	3.47 77%
PEFR (L/s)	10.71	7.66	71%	7.11 66%	6.31 59%
Vext %	---	2.78	---	2.65	2.99

[Handwritten Signature]
4/18

Test comments:

