

CMG HEALTH PROVIDER FORM

Revised 9/06

PATIENT'S NAME: Gregory Borly

VISION

Vision Without Glasses

Vision With Glasses (N/A)

Distant std. Type: Right _____ Left _____

Right 20/20 Left 20/25 Color Blind N

ALLERGIES:

NKDA

ABILITY TO WORK 6-10' ABOVE GROUND LEVEL

BACK AND LIMB HISTORY

Do you have or have you ever had:

| | YES | NO |
|-----------------------------|-------------------------------------|-------------------------------------|
| 1. Injured Knee | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Injured Elbow | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Injured Arm or Shoulder | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Catches in the Back/Pain | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Dislocation (Shoulder) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Broken Bones | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Foot or Ankle Trouble | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Slipped Disc | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

- 9. Disc Trouble
- 10. Pain/Swelling of Joints
- 11. Hand or Wrist Pain
- 12. Neck Pain
- 13. Muscle Sprain or Strain
- 14. Back Strain or Sprain
- 15. Physical Restrictions Regarding Any of The Above
- 16. Other

| | YES | NO |
|--|--------------------------|-------------------------------------|
| 9. Disc Trouble | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Pain/Swelling of Joints | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Hand or Wrist Pain | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. Neck Pain | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13. Muscle Sprain or Strain | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Back Strain or Sprain | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15. Physical Restrictions Regarding Any of The Above | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 16. Other | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Please explain ALL "YES" answers:

(bike accident age 10)

about 5 years

RT knee broken accident @ 10 yrs old RT elbow pulled newel, dislocated RT shoulder 1 yr ago slipped going down stairs - stepped on skateboard

(Please include dates of injury.)

I have reviewed the answers to the "Back and Limb History" above and state that these answers have been recorded accurately and are true and complete responses to these questions.

no problems since

Date: 1/31/08

Applicant Signature: Gregory Borly

Check whether:

Normal (N), Abnormal (A), Not Performed (O)

| | | | |
|--------------------------|---------------------------------------|----------------------------|----------------------------|
| 1. Eyes | <input checked="" type="checkbox"/> N | <input type="checkbox"/> A | <input type="checkbox"/> O |
| 2. Visual Field | <input checked="" type="checkbox"/> N | <input type="checkbox"/> A | <input type="checkbox"/> O |
| 3. Hernias | <input checked="" type="checkbox"/> N | <input type="checkbox"/> A | <input type="checkbox"/> O |
| 4. Spine | <input checked="" type="checkbox"/> N | <input type="checkbox"/> A | <input type="checkbox"/> O |
| 5. Extremities | <input checked="" type="checkbox"/> N | <input type="checkbox"/> A | <input type="checkbox"/> O |
| 6. Hand Function | <input checked="" type="checkbox"/> N | <input type="checkbox"/> A | <input type="checkbox"/> O |
| 7. Neurological, General | <input checked="" type="checkbox"/> N | <input type="checkbox"/> A | <input type="checkbox"/> O |
| 8. Lung Capacity | <input checked="" type="checkbox"/> N | <input type="checkbox"/> A | <input type="checkbox"/> O |

COMMENTS: (Exam notes/results)

non smoker

passed PFT'S

CMG HEALTH PROVIDER FORM page two.

1. Does the applicant currently have a medical condition which would preclude assignment to some of the tasks and duties of the Assembler position?

YES | NO
_____|_____

a. If so, please identify the tasks and duties of the similar position from which the employee would be precluded and the medical reason why you would limit the employee from such activities.

2. Does the applicant have a medical condition which would result in a significant risk of substantial harm to either the applicant or others if the applicant were to perform the tasks and duties of the assembler position?

YES | NO
_____|_____

a. If so, please identify the nature of the potential harm, and the basis for your medical opinion that there is a significant risk of such harm occurring.

3. Is there a medical reason to believe that, because of a medical condition, if any, the applicant is likely to experience sudden or subtle incapacitation such as seizures, blackouts, etc.?

YES | NO
_____|_____

a. If so what is the medical reason for your conclusion?

I recommend that Suzlon Rotor Corporation obtain the following Medical information on this applicant before making a final determination as to the applicant's ability to begin employment activities as an employee at Suzlon:

Date

1-31-08

Medical Provider Signature



Applicant Health Questionnaire

** Please answer every question ** Indicate your answer by circling yes or no ** Any question answered "NO", discuss with the medical provider

Name: Gregory Verly
Home Phone:
Job Applied For:

Definition:

Occasionally = 1-33% of an 10 hour work shift.
Frequently = 34-66% of an 10 hour work shift.
Continuously = 67-100% of an 10 hour work shift

GENERAL WORK SCHEDULE

- Can you work an TEN hour shift? YES/NO
Can you work 2.5 hours without a rest break? YES/NO
Can you work 5.0 hours until a lunch break? YES/NO

LIFTING AND CARRYING

- Can you lift up to 20 pounds continuously? YES/NO
Can you lift up to 50 pounds occasionally? YES/NO
Can you carry up to 20 pounds continuously? YES/NO
Can you carry up to 50 pounds occasionally? YES/NO
Can you lift objects from table level? YES/NO
Can you lift objects from the floor? YES/NO
Can you lift bulky objects? YES/NO

UTILIZATION OF HAND/WRIST/ARM/BODY MOTION

- Can you feel with your fingers to pick up or connect nuts or bolts without seeing them? YES/NO
Can you handle air guns, power wrenches and push buttons with both hands? YES/NO
Can you operate foot pedals with both feet? YES/NO
Can you twist or turn your head frequently? YES/NO
Can you twist or turn you back frequently? YES/NO
Can you perform repetitive motion work with one or both hands? YES/NO
Can you perform repetitive motion work with your upper body and extremities? YES/NO
Can you perform repetitive motion work while handling objects from 1 to 10 pounds? YES/NO

VISION

- Do you have clear vision up to 20 inches? YES/NO
Do you have clear vision up to 20 feet? YES/NO
Do you have depth perception? YES/NO
Do your eyes have the ability to focus on moving objects? YES/NO

Can you walk up stairs? Five or more steps? YES/NO

MENTAL AND HUMAN RELATIONS CHARACTERISTICS

- Can you carry out instructions in written, oral, or diagram form? YES/NO
Can you perform simple addition and subtraction? YES/NO
Can you read and copy figures or count objects and record information accurately? YES/NO
Do you have the ability to understand and recall verbal or written instructions? YES/NO
Do you have the ability to function independently on work tasks without direct supervision? YES/NO
Do you have the ability to communicate and interact with co-workers/supervisors? YES/NO
Can you cope with stressful situations? YES/NO

DEGREE OF STRENGTH

- Can you stand while working 10 hour per shift? YES/NO
Can you push objects using force? YES/NO
Can you pull objects using force? YES/NO

GENERAL PHYSICAL DEMANDS

- Can you balance yourself and parts while working? YES/NO
Can you reach to the floor? YES/NO
Can you stoop over repetitively? YES/NO
Can you reach above your shoulder repetitively? YES/NO
Can you reach out over 18 inches? YES/NO
Can you reach within your chest-waist region to work? YES/NO

HANDS

- Is you dominate hand 100% functional at least 100% of an 10 hour shift? YES/NO
Is your non-dominate hand at least 50% functional 100% of an 10 hour shift? YES/NO
Can both your hands provide primary assistance in handling objects frequently? YES/NO
Can both your hands grasp objects on a frequent and repetitive basis? YES/NO
Can both your hands manipulate small objects (under 2 pounds) frequently? YES/NO
Can both your hands manipulate large objects (over 2 pounds) frequently? YES/NO
Can both your hands hold objects in its palm? YES/NO
Can both your hands have the ability to release objects held? YES/NO
Can the thumb and fingers on both your hands have the ability to touch/feel continuously? YES/NO
Can both your hands hold objects with the strength of up to 15 pounds pressure? YES/NO
Can both your hands pinch objects on a frequent and repetitive basis? YES/NO

WORK ENVIRONMENT

- Can you work indoors continuously? YES/NO
Can you be exposed to temperature extremes from 65-90 degrees? YES/NO
Can you work while exposed to noise? YES/NO
Can you work while exposed to vibration? YES/NO
Can you work around moving equipment? YES/NO
Can you work around dust, fumes and odors? YES/NO
Can you wear a respirator? YES/NO
Can you work around cold air drafts? YES/NO
Can you work around materials, oils, or fumes which may cause allergic sensitivity? YES/NO
Can you stand on cement floors frequently or for prolonged periods? YES/NO
Can you work 6-10' above ground level? YES/NO

Any questions answered "NO" please state what assistance or accommodation can be provided so you may be able

to perform the essential job functions (i.e. assists, equipment, etc.)

AUDIOMETRIC HISTORY

Have you ever had any hearing problems?

YES/NO

If yes, when and where?

YES/NO

Have you ever been exposed to loud noises?

YES/NO

Would you consider your hearing to be:

Good

Have you ever had a previous hearing measurement?

Did you ever have ringing or noise in your ears?

Fair Poor.

YES/NO

YES/NO

In the past 10 years, have any health care providers (including chiropractors) placed medical restrictions on you limiting or prohibiting you from performing any of the physical tasks described on this questionnaire?

YES/NO

Have you ever submitted a workers' compensation claim?

YES/NO

Have you ever been hospitalized in the past five years for a physical or mental illness?

YES/NO

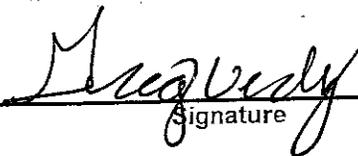
PLEASE READ AND SIGN:

I hereby certify that I have answered these questions to the best of my knowledge and that the answers are complete and true. I also certify that I will answer any questions asked of me by any health care provider performing a "post offer/pre-employment physical examination" on behalf of CMG completely and truthfully.

I understand that falsified information or significant omissions either on this questionnaire or to a health care provider performing a "post-examination/pre-employment" examination may disqualify me from further consideration for employment and will be considered justification for dismissal if discovered at a later date. Further, I hereby authorize all physicians, practitioners, hospitals and institutions by this form (or by a copy hereof) to give the contracted functional assessment medical provider, for inclusion in my medical file, any information they may have regarding the condition of my health when I was under observation or treatment by them. And finally, I allow the medical provider to release to my employer or prospective employer the information contained on this form and any opinions or conclusions that are obtained as a result of this examination.

1-31-08

Date



Signature



CMG, 1711 S Highway 75
Pipestone, MN 56164

STEP 1 – PRE-EMPLOYMENT HEALTH ASSESSMENTS – Pipestone Medical Group

ADDRESS: 920 4th Avenue SW, Pipestone, MN 56164 CALL IMMEDIATELY to schedule your Health Assessment and Drug Screen: 507-825-5700, Ask for Heidi, the Clinic Manager. Be sure to say you are with SUZLON. Please arrive early enough to allow time to complete your Health Questionnaire. Allow up to 1 hour for your exam.

STEP 2 – AUTHORIZATION FOR COLLECTION

DATE OF TEST: 1-31-08

In order to process a laboratory procedure in our facility we are required to obtain a written request signed by a representative from your company for our records. Please complete the company Name and Address and fill in the Employee Name, Date of Birth, Social Security #, Date of Test, Test Requested, and Reason requested and sign the area for company representative.

Name of Employee Greg Verly DOB 3/15/1970
Social Security # 474-82-8220 (Month/day/year)

Test Requested: Urine Drug Screen (DOT)
 Urine Drug Screen (NON-DOT)
 Breath Alcohol (DOT)
 Breath Alcohol (NON-DOT)

Reason Requested: Random **PREEMPLOYMENT** Post-accident Other
 Reasonable Suspicion Follow UP Return to Duty

Signature of company Representative [Signature]

If donor does not have a driver's license or acceptable picture ID, a company rep must accompany the donor to our lab for identification purposes. The donor and the authorized representative must then sign the request to witness the identification of the donor.

INSTRUCTIONS FOR URINE DRUG SCREEN:

1. Donor must bring valid photo ID (Drivers License). If no valid photo ID or acceptable picture available, an authorized representative from company must verify ID of donor.
2. For Drug Screen – Donor must be prepared to give a urine sample for testing.
3. If donor is unable to give urine sample or other sampling issues arise, the donor may be required to remain at the clinic for up to 3 hours.
4. If confirmation testing is necessary, it may take up to one hour to complete testing.
5. A refusal to test, or a positive test, will subject donor to disciplinary action as authorized by DOT regulations or facility drug and alcohol policy.

