

Corporate Health Resources, Inc.
1375 Piccard Drive
Suite 275
Rockville, MD 20850

EXAMINATION CLEARANCE NOTIFICATION

NXT - Corporate Management Group (CMG)

Reference: BASF Brighton CMG

Requested By: Caitlin Scholl
Fax Number: 303-736-4467

From: Nina Newberry

Name: Joseph Washington

Test Date: 04/28/2016

Exam Type: PMU Contracted

Date of Clearance: 05/06/2016

- The individual has been placed on MEDICAL HOLD pending further evaluation.
- The DRUG SCREEN RESULTS for this individual have been received and are Negative.
- The PHYSICAL AND/OR HISTORY REVIEW has been completed. The examinee has been medically cleared as indicated.
- The Lab test has been completed. The examinee has been medically cleared as indicated.
- BAT RESULTS
- Unqualified

Please call the CHR contact noted above at 800-867-0933 if you have any questions.
Thank you for using CHR's Examiner Network.



17931

Occupational Health Evaluation
Medical Clearance Form

* = Required Fields

BASF

The Chemical Company

* Washington Jacob W
Name (Last) (First) (MI)* 5 2 2 5 7 8 3 6 3
(Required Entry) SSN or BASF Emp ID only (Print neatly or type)
 January April July October
 February May August November
 March June September December

(Required Entry) Month of Birth

* Required Field Periodic Other PMU UNTRAINED Pre-Placement* **Required Fields** Physician **MUST** Complete the Following Sections: (based on the examination of this individual and review of the available data)Yes No In determining if this individual is at increased risk of health impairment from the known duties and exposures of the job, are further tests or evaluations needed?* Class I: No Medical Restrictions Class II: Medical Restrictions Class III: Unsuitable for Employment

Medical Clearances

Requested	Cleared For		Requested	Cleared For	
	Yes	No		Yes	No
<input type="radio"/> Benzene	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Inorganic Lead	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Butadiene	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Methylene Chloride	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Chromium	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/> Mobile Equipment Operator	<input checked="" type="radio"/>	<input type="radio"/>
<input type="radio"/> Crystalline Silica	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Nickel	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Diisocyanates	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/> Platinum	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> CMV (DOT) Driver	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/> Respirator (except SCBA)	<input checked="" type="radio"/>	<input type="radio"/>
<input type="radio"/> Ethylene Oxide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SCBA	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Formaldehyde	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Hazmat	<input type="radio"/>	<input type="radio"/>	<u>Must wear corrective eye lenses</u>	<input type="radio"/>	<input checked="" type="radio"/>

Restrictions

Restrictions	Permanent	Temporary	If Temporary		Restriction Removed
			Date to Resume		
R1. No lifting or carrying greater than <input type="text"/> <input type="text"/> lbs.	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R2. No climbing stairs or ladders (specify one). <input type="radio"/> stairs <input type="radio"/> ladder <input type="radio"/> stairs/ladder	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R3. No work at elevated heights.	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R4. No work in confined places.	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R5. No operation of powered vehicles (motor vehicles, fork lift, truck etc.)	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R6. Unable to work in extreme heat or cold.	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R7. No or limited exposure to materials, dust, fumes, chemical vapors and gases as specified: _____	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R8. No excessive exertion.	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R9. Must wear personal protective equipment as specified: _____	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R10. No use of respiratory protective equipment.	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R10a. Limited respirator use: <input type="radio"/> Lightweight (no SCBA) <input type="radio"/> PAPR only <input type="radio"/> Escape only	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R13. May not work more than <input type="text"/> <input type="text"/> hours / day or <input type="text"/> <input type="text"/> hours / week	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>
R12. Other _____	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>

I have informed this individual of the results of this examination and my recommendations. The individual has been notified of any medical condition which would place the individual at increased risk of material impairment of the his / her health as a result of exposure to potential hazards in the workplace.

Comments: _____

* Examining Physician's Signature _____

DR. PAUL RAFORD, M.D.

* Print or stamp Examining Physician's _____

Individual Signature _____

* 04 28 20 16

(Required Entry) Physical date: mm/dd/yyyy

17931