

# CMG HEALTH PROVIDER FORM

Revised 9/06

PATIENT'S NAME: Leo Brianas

**VISION**

Vision Without Glasses

Vision With Glasses ( \_\_\_ N/A)

Distant std. Type: Right 20/25 Left 20/25

Right \_\_\_ Left \_\_\_

Color Blind N

ALLERGIES:

pen

ABILITY TO WORK 6-10' ABOVE GROUND LEVEL

**BACK AND LIMB HISTORY**

Do you have or have you ever had:

YES | NO

YES | NO

- |                             |                                     |                                     |
|-----------------------------|-------------------------------------|-------------------------------------|
| 1. Injured Knee             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 2. Injured Elbow            | <input type="checkbox"/>            | <input checked="" 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              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 6. Broken Bones             | <input type="checkbox"/>            | <input checked="" 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                                      | <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:

*(this is his diagnosis)*  
Rt shoulder went out 1996 - was shooting  
basketball - did not see a doctor

(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.

Date: 11/10/08

Applicant Signature: Leo Brianas

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)

smiles.

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1-10-08

Date

*Cindy S.M.*

Medical Provider Signature

Applicant Health Questionnaire

Name: Leo @ Bianas  
 Home Phone: 605-573-5750  
 Job Applied For: Nose Cones

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

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?

If yes, when and where?

YES/NO

YES/NO

YES/NO

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.

1/10/08

Date

*Leo C. Piana*

Signature