

CMG HEALTH PROVIDER FORM

Revised 9/06

PATIENT'S NAME: Maria Santiago

VISION

Vision Without Glasses

Vision With Glasses N/A

Distant std. Type: Right 20/30 Left 20/20

Right Left

Color Blind pass

ALLERGIES:

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 checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Dislocation | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. Broken Bones | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Foot or Ankle Trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 8. Slipped Disc | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

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

Please explain ALL "YES" answers:

(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: 1/10/06

Applicant Signature: Maria Santiago

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)

PFT'S > OK > Passed

Exam - WNL Difficult at times to communicate due to language barrier. However, all looked normal today. Complete exam performed

H. Tharson

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
 | X

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
 | X

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
 | X

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

Heidi Thorsen PA-C
Medical Provider Signature