CMG HEALTH PROVIDER FORM

Revided 9/06

PATIENT'S NAME: Michael Green

VISION

Vision Without Glasses

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

Vision With Glasses (___ N/A)

Right ____ Left ____ Color Blind Passed

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		X
2. Injured Elbow		X
3. Injured Arm or Shoulder		X
4. Catches in the Back/Pain - Prior	X	
5. Dislocation		X
6. Broken Bones		X
7. Foot or Ankle Trouble		X
8. Slipped Disc		X
9. Disc Trouble		X
10. Pain/Swelling of Joints		X
11. Hand or Wrist Pain		X
12. Neck Pain		X
13. Muscle Sprain or Strain		X
14. Back Strain or Sprain		X
15. Physical Restrictions Regarding Any of The Above		X
16. Other		X

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: 4-2-08 **Applicant Signature:**

Check whether:
Normal (N), Abnormal (A), Not Performed (O)

1. Eyes	N	A	O
2. Visual Field	N	A	O
3. Hernias	N	A	O
4. Spine	N	A	O
5. Extremities	N	A	O
6. Hand Function	N	A	O
7. Neurological, General	N	A	O
8. Lung Capacity	N	A	O

COMMENTS:(Exam notes/results)

passed PFTs

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:

4-2-08
Date

Medical Provider Signature

CMG

Applicant Health Questionaire

Name:	Mike Green
Home Phone:	
Job Applied For:	Finishing

** 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

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

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

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

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

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

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 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

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

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: X **Good** ___**Fair** ___**Poor.**

Have you ever had a previous hearing measurement? YES/NO
Did you ever have ringing or noise in your ears? 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.

4-2-08
Date

Signature