HEALTHworks
Avera Health

Occupational Health Services
4925 North Cliff Avenue
Sioux Falls, South Dakota 57104
(605)322-5100
Fax (605) 322-5101

ATTENTION:

Susie Rennich
Suzlon Rotor Company
1711 S US Highway 75
Pipestone, MN 56164

Participant: Phillip Guillen
Participant ID: 398
SSN: 460-59-9315

Results of Controlled Substance Test

Record Status: Negative
Test Type: Pre-Employment
Collection Date/Time: 02/05/2008 1:50 PM
Batch ID: 20080206
Specimen ID: Z11437682

Sample Type: Urine

Laboratory: Medtox Laboratories, Inc.
402 West County Road D
St. Paul, MN 55112
Collection Site: Worthington Clinic
508 10TH St
Worthington, MN 56187

Substance Tested	Result	Substance Tested	Result
Amphetamines	Negative	Cocaine	Negative
Opiates	Negative	Phencyclidine	Negative
Marijuana	Negative		

Bruce Elkins, MD

2/6/2008
Verification Date

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NON-REGULATED 5 PART DRUG TESTING CUSTODY AND CONTROL FORM

SPECIMEN ID NO. 21437682

MEDTOX LABORATORIES, INC.
402 W County Rd D
St. Paul, MN 55112
(651) 636-7466
(800) 832-3244

STEP 1 To be completed by **COLLECTOR** or **EMPLOYER REPRESENTATIVE** Account # 32176996

A. Employer Name, Address, I.D. No.
SUZLON ROTOR CO
ATTN: DER
1711 SOUTH US HWY 75
PIPESTONE, MN 56164-1597
PI FI

B. MRO Name, Address, Phone and Fax No.
DR. BRUCE ELKINS
HEALTHWORKS
4528 NORTH CLIFF AVE
SIOUX FALLS, SD 57104
PH 605-322-5100 FX 605-322-5197

LAB ACCESSION NO.

Account # 3 2 1 7 6 9 9 4

Donor SSN or Employee I.D. 460-59-9315

C. Donor Name (Last, First) Guillen Phillip

Donor Daytime Phone 5 0 7 3 7 0 2 4 9 0

D. Reason for Test ☒ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Return To Duty ☐ Follow-up ☐ Post Accident ☐ Other (Specify)

E. Collection Site Name
Worthington Specialty Clinic
508 10th St. Worthington, MN 56187

Collector Phone No. 5 0 7 3 7 2 2 9 2 1

Collector Fax No. 5 0 7 3 7 2 1 9 0 2

F. Test(s) Ordered ☐ 88150 5 PANEL

STEP 2: COMPLETED BY COLLECTOR
Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark

Specimen Collection: ☒ Split ☐ Single ☐ None Provided (Enter Remark) ☐ Observed (Enter Remark)

30066

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X Robin L. Funk
Signature of Collector

Robin L. Funk
(PRINT) Collector's Name (First, MI, Last)

Time of Collection 0 1 5 0 ☐ AM ☒ PM

Date (Mo./Day/Yr.) 0 2 0 5 2 0 0 8

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab
☒ DHL ☐ Local Courier ☐ Other

RECEIVED AT LAB:
X
Signature of Accessioner

(PRINT) Accessioner's Name (First, MI, Last) Date (Mo./Day/Yr.)

SPECIMEN BOTTLE(S) RELEASED TO:

Primary Specimen Bottle Seal Intact
☐ Yes
☐ No, Enter Remark Below

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X Phillip Guillen
Signature of Donor

Phillip M. Guillen
(PRINT) Donor's Name (First, MI, Last)

2 / 05 / 08
Date (Mo. / Day /Yr.)

Daytime Phone No. (507) 370-2490

Evening Phone No. ( )

Date of Birth 3 / 30 / 78
Mo. Day Yr.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ DILUTE
☐ REFUSAL TO TEST BECAUSE: ☐ ADULTERATED ☐ SUBSTITUTED

REMARKS

X
Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable requirements, my determination/verification

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON

X
Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

COPY 2 - MEDICAL REVIEW OFFICER COPY - SEND TO MRO

A-14A (8/06) Mfg 11/07

Avera
Worthington
Specialty Clinics

RESPIRATOR MEDICAL RECOMMENDATION

Name: Phillip Guiles SSN: _____

Based on review of OSHA Respirator Health Questionnaire this individual is:

_____Medically approved for al respirators with the exception of SCBA, subject to fit testing.

Based on interview, physical examination and further evaluation as appropriate, this individual is:

__✓__Medically approved for all respirators including SCBA, subject to fit testing.

_____Medically approved for only the following type(s) of respirator(s), subject to fit testing.

- _____Dust Mask
- _____Negative pressure
- _____Powered air purifying
- _____Supplied air
- _____Self-contained breathing apparatus (SCBA)

Copy

_____Employee may decline respirator-requiring assignments for temporary health related difficulties.

_____Respirator assignment must not be for IDLH (Immediate Danger to Life or Health) environments.

_____Employees should not be expected to perform rescue duty or serve as a member of a rescue team. If able to wear a respirator at the time, then rescue duties maybe performed.

_____Requires further medical information/evaluation prior to qualifying for respirator use.

_____Other recommendations and suggested accommodations:

_____

_____

_____

Recommended time period for next exam:

- ☐ 1 year
- ☐ 2 years
- ☐ 5 years
- ☒ 3 years

Employee had been provided with a copy of this written recommendation:

- ☒ Yes
- ☐ No

X _____ 2/7/08.

Sundara C. Nalla MD
508 Tenth St
Worthington MN 56187
(507) 372-2921