

CMG HEALTH PROVIDER FORM

Revised 9/06

PATIENT'S NAME: Reggie monegan

VISION

Vision Without Glasses

Vision With Glasses (___ N/A)

Distant std. Type: Right ___ Left ___

Right ___ Left ___ Color Blind ___

ALLERGIES:

NKA

ABILITY TO WORK 6-10' ABOVE GROUND LEVEL

Color test passed

BACK AND LIMB HISTORY

Do you have or have you ever had:

YES | NO

YES | NO

1. Injured Knee

YES | NO

9. Disc Trouble

YES | NO

2. Injured Elbow

YES | NO

10. Pain/Swelling of Joints

YES | NO

3. Injured Arm or Shoulder

YES | NO

11. Hand or Wrist Pain

YES | NO

4. Catches in the Back/Pain

YES | NO

12. Neck Pain

YES | NO

5. Dislocation

YES | NO

13. Muscle Sprain or Strain

YES | NO

6. Broken Bones

YES | NO

14. Back Strain or Sprain

YES | NO

7. Foot or Ankle Trouble

YES | NO

15. Physical Restrictions Regarding

YES | NO

8. Slipped Disc

YES | NO

Any of The Above

YES | NO

16. Other

YES | NO

Please explain ALL "YES" answers:

1 ankle

(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: _____ Applicant Signature: _____

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 type="checkbox"/> N | <input checked="" type="checkbox"/> A | <input type="checkbox"/> O |

failed PFT's

COMMENTS: (Exam notes/results)

smokes -

offered stop smoking program

FEV1 % 61

repeat after treatment in one week -

[Signature]

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:

*pt given Rx for aduon and albuterol
- will repeat PFTs in one week*

1-11-08

Date

Cindy Soren

Medical Provider Signature

Applicant Health Questionnaire

Name: REGINALD L. MONEGAN
 Home Phone: (507) 425-3332
 Job Applied For: _____

** 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
- Do 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?

Have you ever been exposed to loud noises?

Would you consider your hearing to be:

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?

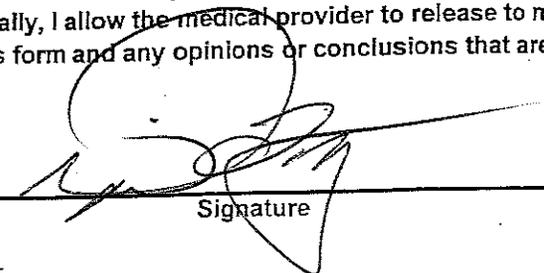
YES/NO

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.

01-11-08
Date


Signature

PHYSICIAN HEALTH PROVIDER FOR

PATIENT'S NAME: Reggie Monegan

Revised 9/06

VISION
Vision Without Glasses

Vision With Glasses (___ N/A)

Distant std. Type: Right ___ Left ___

Right ___ Left ___ Color Blind ___

ALLERGIES:

NKA

ABILITY TO WORK 6-10' ABOVE GROUND LEVEL

Color test passed

BACK AND LIMB HISTORY

Do you have or have you ever had:

	YES	NO
1. Injured Knee		✓
2. Injured Elbow		✓
3. Injured Arm or Shoulder		✓
4. Catches in the Back/Pain		✓
5. Dislocation		✓
6. Broken Bones		✓
7. Foot or Ankle Trouble	✓	
8. Slipped Disc		✓

- 9. Disc Trouble
- 10. Pain/Swelling of Joints
- 11. Hand or Wrist Pain
- 12. Neck Pain
- 13. Muscle Sprain or Strain
- 14. Back Strain or Sprain
- 15. Physical Restrictions Regarding Any of The Above
- 16. Other

	YES	NO
9. Disc Trouble		✓
10. Pain/Swelling of Joints		✓
11. Hand or Wrist Pain		✓
12. Neck Pain		✓
13. Muscle Sprain or Strain		✓
14. Back Strain or Sprain		✓
15. Physical Restrictions Regarding Any of The Above		✓
16. Other		✓

Please explain ALL "YES" answers:

L Ankle

(Please include dates of injury.)

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Date: Applicant Signature:

Check whether:

Normal (N), Abnormal (A), Not Performed (O)

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- 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

Failed PFT's

COMMENTS:(Exam notes/results)

Smokes -

Offered step smoking program

FEV1 % 61

repeat after treatment in one week -

* 1-18-08 - passed PFT's with Advair



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- will repeat PFT's in one week*

1-11-08

Cindy Saxon

Date

Medical Provider Signature

**1-18-08*

passed PFT's with use of Advair

