AVERA WORTHINGTON SPECIALTY CLINICS
GENERAL EMPLOYEE PHYSICAL

I authorize the release of my records from this visit to my employer.

x _____ 1/8/08
(Patient Signature) *(Date)*

Patient Name: William Clipp **DOB:** 4/4/79 **DATE:** 1/8/08

Physical Exam: Wt 165 Ht 5'10½ B/P 118/76 P 68

General Appearance:	X Normal	___Abnormal
Head:	X Normal	___Abnormal
Eyes:	X Normal	___Abnormal
Distance Vision R 40 L 50 with/		without corrective lenses
Holmgrens Color Pass (Fail) Color blind		
Ears:	X Normal	___Abnormal
Nose:	X Normal	___Abnormal
Mouth/Teeth:	X Normal	___Abnormal
Throat:	X Normal	___Abnormal
Neck:	X Normal	___Abnormal
Chest/Lungs:	X Normal	___Abnormal
Heart Vascular:	X Normal	___Abnorma
Abdomen:	X Normal	___Abnorma
Skeletal:	X Normal	___Abnorma
Lymphoid:	X Normal	___Abnorma
Skin:	X Normal	___Abnorma
UPPER EXTREMITY:		
Inspection:	X Normal	___Abnorma
Strength testing:	X Normal	___Abnorma
Abductor pollicis brevis:	X Normal	___Abnorma
Opponens pollicis:	X Normal	___Abnorma
Shoulder range of motion:	X Normal	___Abnorma
SPINE:		
Inspection:	X Normal	___Abnorma
Range of motion:	X Normal	___Abnorma
LOWER EXTREMITIES:		
Inspection:	X Normal	___Abnorma
Heel/Toe walk strength:	X Normal	___Abnorma
Proximal strength:	X Normal	___Abnorma
Deep tendon reflex symmetry	X Normal	___Abnormal
Achilles:	X Normal	___Abnormal
Patellar:	X Normal	___Abnormal
Knee:		
Collateral stability, Lachman's:	X Normal	___Abnormal
Inflammation or effusion:	X Normal	___Abnormal

AudiöScope™ Screening Results

☐ 20db HL ☒ 25db HL ☐ 40db HL

Patient William Clipp Date 1/8/08

Tested by Schanks

Welch Allyn
4341 State Street Road
P.O. Box 220
Skaneateles Falls, NY 13153-0220
USA

Y = Response N = No Response	500	1000	2000	4000
Right Ear	Y	Y	Y	Y
Left Ear	X	X	X	X

Frequency (Hz)

Form 55230 Rev. D

X Yes ___No - Able to perform functions of attached job description.

Physician's Signature: _____ Date: 1/8/08

Avera
Worthington
Specialty Clinics

RESPIRATOR MEDICAL RECOMMENDATION

Name: William Clipp SSN: 460-85-6872

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:

__X__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)

_____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
- ☐ _____

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

- ☒ Yes
- ☐ No

X_____ 1/8/08

MEK & Associates | **Spirotech Integrity PFT** | ***Snellville, GA 30078***

(**SN#:** *7806067 V4M* **Version:** *4.1.0*) **Calibration Date:** 01/08/2008

Name: **WILLIAM CLIPP** **Test Date:** 01/08/2008

ID: 008-14-411 **Age:** 28 **Sex:** M **Technician:** L. BRANDT **Temperature:** 22.6 C

Height: 71.0 in **Race:** Caucasian **Physician:** G. CLARK **Pressure:** 760.0 mm Hg

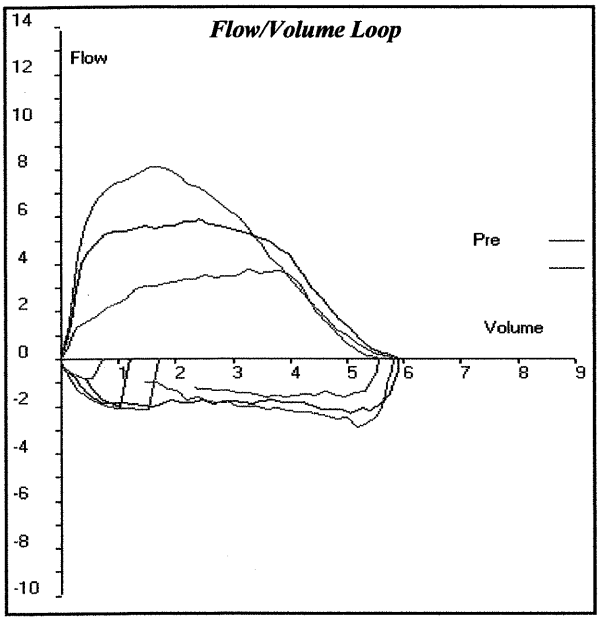
Weight: 168.0 lb **BMI:** 23.4 **BTPS:** 1.08

Comments: *SUZLON PRE EMPLOY PHYSICAL* **Predicted Set:** **Knudson-1983**

Pre-Interpretation: Modified **Test Quality:** 3 of 3 **Effort/Position:** Maximal/Sitting **Criteria Met:** Yes

Normal expiratory flows and a normal FVC. SYR VOL 3.88 MEAS VOL 3.83

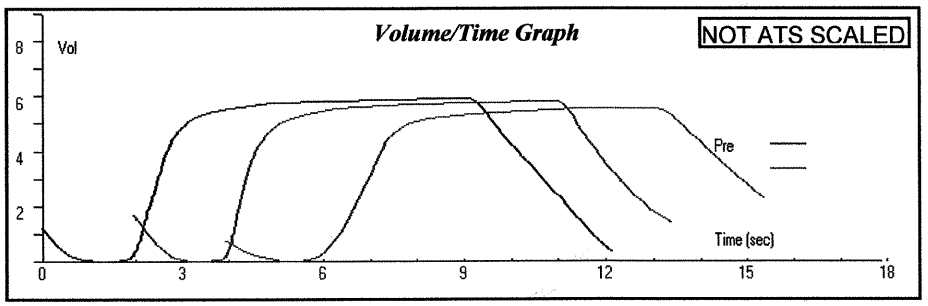
Post-Interpretation: **Test Quality:** 0 of 0 **Effort/Position:** **Criteria Met:** No



Physicians Comments:

Normal Spirometry

Physicians Signature:



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Weight: 168.0 lb **BMI:** 23.4

Temperature: 22.6 C
Pressure: 760.0 mm Hg
BTPS: 1.08

Comments: *SUZLON PRE EMPLOY PHYSICAL*

Predicted Set: **Knudson-1983**

Spirometry

Pre Results

01/08/2008 15:47

Parameter	Predicted	Best: # 2	%Pred
FVC	5.60	5.94	105.99
FEV.5	3.45	3.64	105.49
FEV1	4.66	4.86	104.28
FEV3	5.25	5.75	109.56
PEFR	9.98	8.32	83.38
FEF 25%-75%	4.91	5.05	102.90
FEV1/FVC	0.84	0.82	97.91
FEV3/FVC		0.97	
FET		7.08	
MVV	154.38		

Reproduciblity:	%	Vol	Cmet
FVC (5% / 200 ml)	1.85	0.11	Y
FEV1 (5% / 200 ml)	0.21	0.01	Y
PEFR (15% / 300 ml)	27.04	2.25	N

NOTICE: *DLCo results are based on the following values: Hb =* g/dl, *COHb =* g/dl

Avera Worthington Specialty Clinics 508 Tenth Street Worthington, MN 56187 Form 856

URINALYSIS

#2-014 01-08-08
Color: Yellow
Clarity: Clear
GLU Negative
BIL Negative
*KET Trace
SG 1.025
pH 6.0
PRO Negative
URO 0.2 EU/dL
NIT Negative
BLO Negative
LEU Negative

NORMALS

GLU - Neg NIT - Neg SG - 1.003-1.030
BIL - Neg BLO - Neg URO - 0.2-1.0
KET - Neg LEU - Neg
PRO - Neg pH - 5-8

MICROSCOPIC

_____ RBC/hpf
_____ WBC/hpf
_____ CASTS/pf
_____ EPITH
_____ MUCOUS THREAD
_____ BACTERIA
_____ AMOR, URATES
_____ AMOR. PHOSPHATES
_____ CRYSTALS
_____ YEAST
_____ TRICHOMONAS
_____ OTHER

_____ HANGING DROP
_____
_____ FLUERY
_____ KOH
_____ OCCULT BLOOD
_____ POST VAS CHECK

HEMATOLOGY

Body fluid source: _____

_____ WBC ((200/mm3)
_____ Crystals (Absent)

_____ Sed Rate M(0-15) F(0-20)mm/hr
_____ Retic Count (0.5 - 1.5%)

CHEMISTRY

_____ BNP (0 - 100 pg/ml)
_____ Hgb A1C (3.0 - 6.0%)
_____ Lead ((10 ug/dl)

Microalbumin:

_____ Albumin ((37 mg/L)
_____ Creatinine ((15 - 500 mg/dl)
_____ A/C Ratio ((16 mg/G)

3 Hr. Glucose Tolerance Tests

_____ Fasting Glucose
_____ 1/2 Hr. Glucose
_____ 1 Hr. Glucose
_____ 2 Hr. Glucose
_____ 3 Hr. Glucose

COAGULATION

_____ Bleeding Time (2.3 - 9.5 min.)
_____ Protime (9.5 - 10.8 sec.)
_____ INR
_____ PTT (24 - 33 sec.)

IMMUNOLOGY

_____ H. Pylori (Negative)
_____ HCG Serum (Negative)
_____ HCG Urine (Negative)
_____ Mono Test (Negative)
_____ RA Screen (Negative)
_____ RA Titer (Negative)

MICROBIOLOGY

_____ Giardia Antigen (Negative)
_____ Ova & Parasites (None Seen)
_____
_____ Stool For Fat
_____ Stool For WBC
_____ Strep Screen
_____ Influenza A (Negative)
_____ Influenza B (Negative)

** REPRINT ** REPRINT **
1/08/08 330p WILLIAM E CLIPP PU PULMONARY FUNCTIO

TX: 6307214 1092 PULMONARY FUNCT AVERA WORTHINGTON SPE 040479 28

HX: Q000997468W WILLIAM E CLIPP 979 219 8115 CLARK MD

PAT .00
INS .00
LMP:
EDC:

DIAGNOSIS CODES
"FIRST DX MUST MATCH FIRST LINE OF DICT."
1. _____
2. _____
3. _____
4. _____

X

Reasons: PFT # 1
NO INTER

.00 .00 .00 .00 .00 1 1 0 HIPAA PRIVACY NOTICE

OVH

Next Apt. 1/08/08, 330p

SSN Review:

Regulations (Standards - 29 CFR)

OSHA Respirator Medical Evaluation Questionnaire (Mandatory). - 1910.134 App C

Regulations (Standards - 29 CFR) - Table of Contents

• **Part Number:**	1910
• **Part Title:**	Occupational Safety and Health Standards
• **Subpart:**	I
• **Subpart Title:**	Personal Protective Equipment
• **Standard Number:**	1910.134 App C
• **Title:**	OSHA Respirator Medical Evaluation Questionnaire (Mandatory).

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Can you read (circle one): (Yes)/No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: 1-8-08

2. Your name: William Clipp

3. Your age (to nearest year): 28

4. Sex (circle one): (Male)/Female

5. Your height: 5 ft. 11 in.

6. Your weight: 170 lbs.

7. Your job title: New hire

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): 919-219-8115

9. The best time to phone you at this number: any time

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):
a. ✓ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
b. ✓ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s): air purifying

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you **ever had** any of the following conditions?

a. Seizures (fits): Yes/No
b. Diabetes (sugar disease): Yes/No
c. Allergic reactions that interfere with your breathing: Yes/No
d. Claustrophobia (fear of closed-in places): Yes/No
e. Trouble smelling odors: Yes/No

3. Have you **ever had** any of the following pulmonary or lung problems?

a. Asbestosis: Yes/No
b. Asthma: Yes/No
c. Chronic bronchitis: Yes/No
d. Emphysema: Yes/No
e. Pneumonia: Yes/No
f. Tuberculosis: Yes/No
g. Silicosis: Yes/No
h. Pneumothorax (collapsed lung): Yes/No
i. Lung cancer: Yes/No
j. Broken ribs: Yes/No
k. Any chest injuries or surgeries: Yes/No
l. Any other lung problem that you've been told about: Yes/No

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath: Yes/No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No

d. Have to stop for breath when walking at your own pace on level ground: Yes/No
e. Shortness of breath when washing or dressing yourself: Yes/No
f. Shortness of breath that interferes with your job: Yes/No
g. Coughing that produces phlegm (thick sputum): Yes/No
h. Coughing that wakes you early in the morning: Yes/No
i. Coughing that occurs mostly when you are lying down: Yes/No
j. Coughing up blood in the last month: Yes/No
k. Wheezing: Yes/No
l. Wheezing that interferes with your job: Yes/No
m. Chest pain when you breathe deeply: Yes/No
n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you **ever had** any of the following cardiovascular or heart problems?

a. Heart attack: Yes/No
b. Stroke: Yes/No
c. Angina: Yes/No
d. Heart failure: Yes/No
e. Swelling in your legs or feet (not caused by walking): Yes/No
f. Heart arrhythmia (heart beating irregularly): Yes/No
g. High blood pressure: Yes/No
h. Any other heart problem that you've been told about: Yes/No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes/No
b. Pain or tightness in your chest during physical activity: Yes/No
c. Pain or tightness in your chest that interferes with your job: Yes/No
d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
e. Heartburn or indigestion that is not related to eating: Yes/ No
f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you **currently** take medication for any of the following problems?

a. Breathing or lung problems: Yes/No
b. Heart trouble: Yes/No
c. Blood pressure: Yes/No
d. Seizures (fits): Yes/No

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No
b. Skin allergies or rashes: Yes/No
c. Anxiety: Yes/No
d. General weakness or fatigue: Yes/No
e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees

who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever lost** vision in either eye (temporarily or permanently): Yes/No

11. Do you **currently** have any of the following vision problems?

a. Wear contact lenses: Yes/No
b. Wear glasses: Yes/No
c. Color blind: Yes/No
d. Any other eye or vision problem: Yes/No

12. Have you **ever had** an injury to your ears, including a broken ear drum: Yes/No

13. Do you **currently** have any of the following hearing problems?

a. Difficulty hearing: Yes/No
b. Wear a hearing aid: Yes/No
c. Any other hearing or ear problem: Yes/No

14. Have you **ever had** a back injury: Yes/No

15. Do you **currently** have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No
b. Back pain: Yes/No
c. Difficulty fully moving your arms and legs: Yes/No
d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
e. Difficulty fully moving your head up or down: Yes/No
f. Difficulty fully moving your head side to side: Yes/No
g. Difficulty bending at your knees: Yes/No
h. Difficulty squatting to the ground: Yes/No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:_____

_____

_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No
b. Silica (**e.g.**, in sandblasting): Yes/No
c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
d. Beryllium: Yes/No
e. Aluminum: Yes/No
f. Coal (for example, mining): Yes/No
g. Iron: Yes/No
h. Tin: Yes/No
i. Dusty environments: Yes/No
j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures: with previous work exposures - always using respiratory protective equipment

4. List any second jobs or side businesses you have:

5. List your previous occupations: Petroleum brander, welder, carpenter

6. List your current and previous hobbies:

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No
b. Canisters (for example, gas masks): Yes/No
c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No
b. Emergency rescue only: Yes/No
c. Less than 5 hours **per week:** Yes/No
d. Less than 2 hours **per day:** Yes/No
e. 2 to 4 hours per day: Yes/No
f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. **Light** (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.

b. **Moderate** (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of moderate work effort are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. **Heavy** (above 350 kcal per hour): Yes/No

No exercise limit
No lifting limit

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling; standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:_____

paper suit

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

Fiber glass

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the second toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the third toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
The name of any other toxic substances that you'll be exposed to while using your respirator:

_____
_____
_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

_____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998]

Next Standard (1910.134 App D)

Regulations (Standards - 29 CFR) - Table of Contents

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Occupational Safety & Health Administration
200 Constitution Avenue, NW
Washington, DC 20210

CMG
CORPORATE MANAGEMENT GROUP

CMG, 1711 S Highway 75
Pipestone, MN 56164

3pm - w/out paperwork done
3:15pm - w/ done
3:30pm - PFT
4pm - Dr. Clark Physical @ 4

STEP I – PRE-EMPLOYMENT HEALTH ASSESSMENTS – Worthington – AVERA HEALTHWORKS
ADDRESS: 508 10th Street, Worthington, MN 56187
CALL IMMEDIATELY to schedule your Health Assessment and Drug Screen: 507-372-2921, Ask for Kelly, the Clinic Manager. Be sure to say you are with SUZLON. Please arrive early enough to allow time to complete your Health Questionnaire. Allow up to 1 hour for your exam.

STEP 2 – AUTHORIZATION FOR COLLECTION

DATE OF TEST: _____

In order to process a laboratory procedure in our facility we are required to obtain a written request signed by a representative from your company for our records. Please complete the company Name and Address and fill in the Employee Name, Date of Birth, Social Security #, Date of Test, Test Requested, and Reason requested and sign the area for company representative.

Name of Employee William Clipp DOB 4-4-79
Social Security # 460-85-6872 (Month/day/year)
Test Requested: _____Urine Drug Screen (DOT)
_____**Urine Drug Screen (NON-DOT)**
_____Breath Alcohol (DOT)
_____Breath Alcohol (NON-DOT)
Reason
Requested: _____ Random **X PREEMPLOYMENT** ____Post-accident ____Other
_____Reasonable Suspicion ____Follow UP _____Return to Duty

Signature of company Representative Sarah Ewart

If donor does not have a driver's license or acceptable picture ID, a company rep must accompany the donor to our lab for identification purposes. The donor and the authorized representative must then sign the request to witness the identification of the donor.
INSTRUCTIONS FOR URINE DRUG SCREEN:

1. Donor must bring valid photo ID (Drivers License). If no valid photo ID or acceptable picture available, an authorized representative from company must verify ID of donor.
2. For Drug Screen – Donor must be prepared to give a urine sample for testing.
3. If donor is unable to give urine sample or other sampling issues arise, the donor may be required to remain at the clinic for up to 3 hours.
4. If confirmation testing is necessary, it may take up to one hour to complete testing.
5. A refusal to test, or a positive test, will subject donor to disciplinary action as authorized by DOT regulations or facility drug and alcohol policy.