



**HealthONE Occupational Medicine/Rehabilitation
at North Suburban**

9195 Grant Street, Suite 100
Thornton, CO 80229

FAX COVER SHEET

Date: ___/___/___

Time: _____ AM / PM

To:

Corporate Management Group

Fax: 303-736-7767

Fax: _____

From: _____

Phone: 303-292-0034
 303-451-7700
 Fax: 303-292-0097
 303-252-9474

Re: _____

Number of pages including cover sheet: _____

Notes: _____

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Occupational Medicine & Rehabilitation at North Suburban

9195 Grant Street Suite #100 Thornton, CO 80229 Phone 303-292-0034 Fax 303-292-0097

OSHA ASBESTOS/HAZARDOUS MATERIALS/ RESPIRATOR CERTIFICATION

In accordance with OSHA regulations 29 CFR 192.58 Asbestos 29 CFR 1910.120(f) Hazardous Materials 29 CFR 1910.134(b) Respirator Certification

The examining physician will provide the employer with a written opinion, which shall contain the following:

This is to certify that on this date: 19 Jan 2016, and in accordance with the regulations as indicated above, I have performed a comprehensive examination on William Pagan, whose social security number is 521 81 5674.

Base on my findings, I have determined that this individual:

X MAY MAY NOT wear a respirator or device while performing his/her required work tasks, and X IS IS NOT medically cleared for work with X ASBESTOS X HAZARDOUS MATERIALS.

The results of my examination:

Have X Have NOT detected a medical condition which would place the employee at increased risk of material health impairment from exposure to:

X Respirator Equipment X ASBESTOS X HAZARDOUS MATERIALS.

IN accordance with OSHA requirement, I have fully explained the results of the medical examination and laboratory tests to the above named patient.

Comments:

Four horizontal lines for handwritten comments.

A complete medical examination on the above named individual will be forwarded to the employer pending final review and interpretation of any additional medical data collected.

Handwritten signature of R. Drapacau Do, Examining Physician



Thornton Occupational Medicine
9195 Grant Street #100
Thornton, CO 80229
303-292-0034

Respirator Fitness Letter

Date: 19 Jan 2016

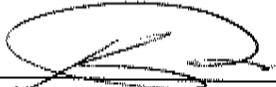
To Whom It May Concern:

We have recently completed a respirator review on William Pyles
Per your request. This letter is to certify whether he/she is fit to wear a respirator while performing his/her job activities per OSHA 1910.134.

1. fit Unfit to wear an air-purifying respirator while performing present job activities.
2. Medical limitations or workplace conditions include:
None
3. Follow up medical evaluations are needed as follows:
None
4. We have provided the employee/employer with a copy of this written recommendation on _____ (date).

These examination results remain confidential and will be kept on file in our office.

Cordially,

 K Drapeau DO Date: 1-19-16
Jeffrey Hawke, M.D.
Arthur Kuper, D.O.

North Suburban
9195 Grant Street Ste. 100
Thornton, Colorado 80229
303.292.0034 Phone
303.292.0097 Fax

Health
ONE

Occupational Health

Patient Name William Pyle Social Security # 521 81 5674

Date of Birth 02-13-88 Employer BASF

Vision Testing Section

Visual Acuity

Uncorrected

	Distant	Near
OD	20/30	20/20
OS	20/30	20/20
OU	20/30	20/20

Corrected

	Distant	Near
OD	20/	20/
OS	20/	20/
OU	20/	20/

Visual Fields

R	85°
L	85°

Ishihara Color Vision Test

of plates correct 13 incorrect 1

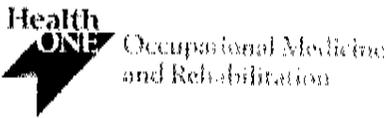
Plate Number	Correct	Response
Plate #1	12	12
Plate #2	8	8
Plate #3	5	5
Plate #4	29	29
Plate #5	74	74
Plate #6	7	7
Plate #7	45	45
Plate #8	2	2
Plate #9	No Number	"2"
Plate #10	16	16
Plate #11	Trace Line Correctly	traced correctly
Plate #12	35	35
Plate #13	96	96
Plate #14	Trace Line Correctly	traced correctly

Does the Employee Wear Glasses for Distance? YES/NO

Does the Employee Wear Glasses for Reading? YES/NO

Patient Signature _____ DATE _____

Examiner's Signature Janet Pyle DATE 1.19.16



HEARING TEST FORM

Employee Identification

Last Name XXXXX <u>Pifer</u>		First Name <u>William</u>	Middle Name	Employee ID#
Dept/Code		Job/Code	Work Shift	Shift Length
Audiometric Information			Test Date: <u>1/19/16</u>	Test Time: <u>3:10</u> am/pm
Test Type: <input type="checkbox"/> Baseline <input type="checkbox"/> Annual/Periodic <input type="checkbox"/> Retest <input type="checkbox"/> Rehire <input type="checkbox"/> Exit				
Audiometer Make/Model: <u>Tremetrics / RAS500</u>			Last Annual Calibration Date: <u>1-6-16</u>	
OSHA sound room requirements met? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Technician: <u>Linae Perez</u>			Technician:	
Testing Company: <u>HCA</u>				
Employee Noise Exposure				
High noise exposure within 14 hours: <input type="checkbox"/> Yes <input type="checkbox"/> No			Last noise exposure: _____ hours ago	
Hearing protection used before test: <input type="checkbox"/> Yes <input type="checkbox"/> No			TWA:	Sound Level:
Hearing Protection Devices		Otososcopic Screening		
Type Used Specify Model/Size		Left	Right	
<input type="checkbox"/> Foam plug		<input type="checkbox"/>	Was Not Done <input type="checkbox"/>	
<input type="checkbox"/> Pre-molded plug		<input checked="" type="checkbox"/>	Normal <input checked="" type="checkbox"/>	
<input type="checkbox"/> Custom plug		<input type="checkbox"/>	Abnormal <input type="checkbox"/>	
<input type="checkbox"/> Earmuff		<input type="checkbox"/>	Partial blockage <input type="checkbox"/>	
<input type="checkbox"/> Plug & Muff		<input type="checkbox"/>	Total blockage <input type="checkbox"/>	
<input type="checkbox"/> Electronic		<input type="checkbox"/>	Other <input type="checkbox"/>	
<input type="checkbox"/> Other				
Hearing Protection Fit Check: <input type="checkbox"/> Proper <input type="checkbox"/> Poor <input type="checkbox"/> Re-instructed <input type="checkbox"/> Replaced				
Test Comments: 				
Employee Training:				
The following topics have been explained to me:				
1. The effects of noise on hearing				
2. The purpose of the hearing test & explanation of procedures				
3. Hearing protection use, care, fit and advantages/disadvantages				
Employee Signature: 			Date: <u>19 Jan 2016</u>	

OCC HEALTH

DATE: 01/19/16
TIME: 16:30:00

PATIENT:

CURRENT AUDIOGRAM

FREQ.	L/DB	R/DB
1000 HZ	05	05
500 HZ	05	00
V1000 HZ	05	05
2000 HZ	00	00
3000 HZ	05	00
4000 HZ	00	10
6000 HZ	20	15
8000 HZ	20	15
AVG 2,3,4	001.7	003.3

TEST ID: 0003619110615380

ELAPSED TIME = 03:52

TEST TYPE = NOT BASELINE
TEST MODE = PULSED
M = MANUALLY TESTED FREQ

TREMETRICS RAS500+
SERIAL NUMBER...12115380
SOFTWARE REV. 2.19H-0102
CALIBRATION: 01/06/16
CAL. ANSI S3.6 1989

PATIENT:
W. Pifer

EXAMINER:
Linae Perez

QUESTION ANSWERS

LAST NAME:
FIRST NAME:
DOB:
SEX:
JOB TYPE:
LOCATION:
PROTECTION:
EXPOSURE:

NORTH SUBURBAN OCC MED

Pulmonary Function Report

Name: PYFER, WILLIAM
 Height at test (in): 74
 Weight at test (lb): 195
 Ethnic group: Caucasian
 Predicteds: NHANES III
 Calibration date: 01/19/16 07:13 AM
 Calibrated by: LENA E

ID: 5674
 Sex: Male
 Age at test: 27

DOB: 02/13/1988

Software version: 2.7

Test series created: 01/19/16 03:47 PM

Report printed: 01/19/16 03:48 PM

Interpretation: Normal expiratory flows and a normal FVC. This interpretation is valid only upon physician review and signature.

Physician:
 Technician:

Number of efforts performed: 3

Pre-	Pred	Best	%Prd	2nd	%Prd	3rd	%Prd
FVC	6.21	6.74	108%	6.45	104%	6.51	105%
FEU1	5.06	4.83	96%	4.94	98%	4.49	89%
FEU1/FVC	0.82	0.72*	87%	0.77	93%	0.69*	84%
FEF25-75	5.01	3.77	75%	4.36	87%	3.02*	60%
PEFR	11.16	10.58	95%	7.43*	67%	7.44*	67%
Temp	--	5.27	--	2.69	--	5.29	--
Uext%	--	1.35	--	2.91	--	1.72	--

Cautions:
 Usability
 Acceptability
 Reproducibility

Time

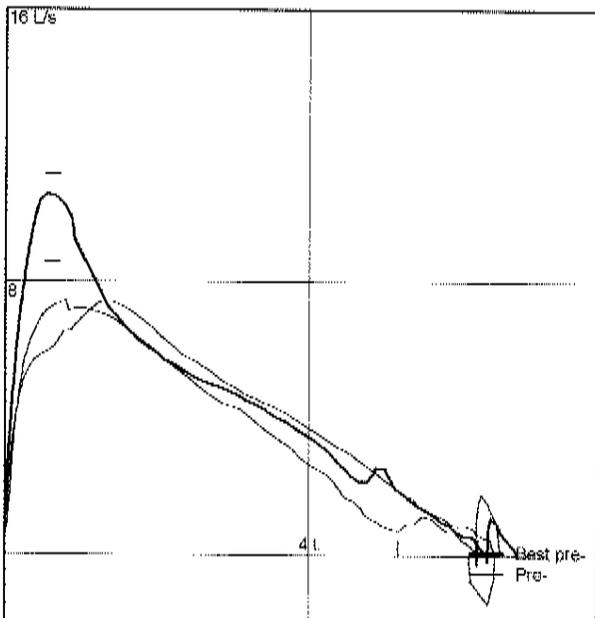
Time
V

Time
V,F

Test series comment:

FVC Flow vs. Volume

Pre-



FVC Volume vs. Time

Pre-

