Employee Name	ANDRZEJ BAGINSKI
Current Asbestos License	1/31/2018
Current Asbestos Training	4/4/2017
Current Medical	7/20/2017
Current Respirator Fit Test	3/12/2018
Other	
10 Hour OSHA	11/28/2018
PPE, Ergonomics & Hazard Asmt	10/28/2016
Polychlorinated Biphenyl	2/21/2016
Lead Awareness	5/31/2015
2 Hour Lead Awareness	6/6/2009

State of Connecticut

Lookup Detail View

Name

Name
ANDRZEJ BAGINSKI

License Information

lookup

License Type	License Number	Expiration Date	Granted Date	License Name	License Status	Licensure Actions or Pending Charges
Asbestos Abatement Worker	48	01/31/2018	05/15/2000	Andrzej Baginski	ACTIVE	None

Generated on: 1/26/2017 11:25:01 AM

Environmental Training and Assessment

Certificate of Completion

Asbestos Abatement Worker
Refresher Training Course
awarded To

Andrzey Baginski
53 Alden Street
New Britain CT 06053

Has successfully completed, and passed an examination covering the contents of the **one (1) day 8 Hour Refresher Training Course for Asbestos Abatement Worker.** This course is accredited by the State of Connecticut, and is in accordance with the EPA Revised MAP for accreditation under the TSCA Title II.

Course Date: 4/4/2016 Examination Grade: 86%
Examination Date: 4/4/2016 Certificate Number: AWR-01714
Expiration Date: 4/4/2017

Stephen J. Craig, Training Manager

Boston Lead Company, LLC
dba
Environmental Training and Assessment
62 Washington Street
Middletown, CT 06457
860-347-7277

Concentra Medical Centers (CT)
972A W Main St New Britain, CT 06053
Phone: (860) 827-0745 Fax: (860) 827-0824

EMPLOYER AUTHORIZATION AND INFORMATION FOR RESPIRATORY EVALUATION

EMPLOYER TO COMPLETE THE FOLLOWING :

Employee Name: Baginski, Andrzej

Address: 53 Alden St
Apt-1
NEW BRITAIN CT 06053

Employer: AIG (Abatement Industries Group) FKA Pike Falls

Employee SSN: XXX-XX-2352

Check Type of Respirator(s) To Be Used (Check ✓ALL that apply)

- ☐ Air-purifying (non-powered)
- ☐ Air-purifying (powered)
- ☐ Atmosphere supplying Respirator
- ☐ Combination air-line and SCBA
- ☐ Continous-Flow Respirator
- ☐ Supplied-Air Respirator
- ☐ Open Circuit SCBA
- ☐ Closed Circuit SCBA
- ☐ Dust Mask
- ☐ 1/2 Face with Canisters
- ☐ Full Face with Canisters

Make: _____ Model: _____ Cartridge: _____

Special Work Conditions (Check ✓ ALL That Apply When Wearing Respirator)

- ☐ High Places
- ☐ Enclosed Places
- ☐ Protective Clothing
- ☐ Temperature Extremes
- ☐ Mostly Cold
- ☐ Mostly Hot
- ☐ Other: _____

Questionare will be: ☐ HAND CARRIED ☐ MAILED ☐ OTHER

Extent of Useage (Check ✓ALL that apply)

- ☐ On a daily basis _____ Total Hours
- ☐ Occasionally - but not more than twice a week ____ Total Hours
- ☐ Rarely - or for Emergency situations only ____ Total Hours

Expected Physical Effort Required (Check ✓ALL that apply)

- ☐ Light
- ☐ Moderate
- ☐ Heavy

Exposure to Hazardous Materials (Check ✓ALL that apply)

- ☐ Arsenic
- ☐ Benzene
- ☐ Coke Oven
- ☐ Cotton Seed / Dust
- ☐ Cadmium
- ☐ Formaldehyde
- ☐ Methylene Chloride
- ☐ Lead
- ☐ Textiles
- ☐ Chromium

Other(s): _____

EVALUATION AUTHORIZATION BY: _____
Signature of Employer Representative

DO NOT WRITE BELOW THIS LINE DO NOT WRITE BELOW THIS LINE DO NOT WRITE BELOW THIS LINE

PLHCP[1] WRITTEN STATEMENT for RESPIRATORS (EMPLOYER)

PHYSICIAN WILL COMPLETE THE FOLLOWING

This report may contain confidential medical information and is intended for the designated employer contact only. The Americans with Disabilities Act (ADA) imposes very strict limitations on the use of information obtained during physical examination of qualified individuals with disabilities. All information must be collected and maintained on seperate forms, in seperate files, and must be treated as a confidential medical record, with the following exceptions:

- Supervisors and managers may be informed about necessary restrictions on the work or duties of an employee and necessary accommodations.
- First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment.

Based upon my findings, I have determined that this individual (Check ✓ALL that apply)

- ☐ Employee must schedule a medical examination with **Concentra Medical Centers (CT)** prior to respirator approval and usage.
- ☒ Class I - No Restrictions on Respirator Use
- ☐ Class II - Some Specific Use Restrictions
- ☐ To be used for Emergency Response or Escape Only
- ☐ Other: _____
- ☐ Class III - Respirator Use is NOT PERMITTED
- ☐ Further Testing / Evaluation is Required. [2]
- ☐ Fit Test Required
- ☐ Fit Test Performed Satisfactorily
- ☐ Fit Test Performed Unsatisfactorily
- ☐ Fit Test NOT Performed at: **Concentra Medical Centers (CT**
- ☐ Special prescription eyewear needed to accommodate respirator
- ☐ Special prescription eyewear needed to accommodate respirator
- ☐ Facial hair needs to be shaved to assure tight seal on certain face masks.

[1] Physician or other Licensed Healthcare Professional

[2] Employee must seek further medical evaluation by a private physician who must submit a report to **Concentra Medical Centers (CT)** of his/her findings to

(Check ✓ ALL that apply)

- ☒ The above individual HAS been examined for respirator fitness in accordance with 29 CFR 1910.134. This limited evaluation is specific to respirator use only. Employees should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.
- ☐ The above individual HAS NOT been examined by me for respirator fitness. The employee's medical evaluation consisted of a review of OSHA's Medical Evaluation Questionnaire in Appendix C Part A Section 2. In accordance with 29 CFR 1910.134, this limited evaluation is specific to respirator use only. Employees would be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.
- ☐ In accordance with specific OSHA requirements, I have informed the above named individual of the results of this evaluation and of any medical conditions resulting from exposures that may require further explanation or treatment. Where applicable, the above named individual has been informed of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos, lead and/or other chemical exposure(s).

K Schwarz PAC
Physician's Signature

Schwarz
Physician's Name (Printed)

Schwarz 382 CT
Physician's License Number (Optional in Most States)

7.26.16
Date of Exam

7.20.17
Expires On

Concentra Medical Centers (CT)
972A W Main St New Britain, CT 06053
Phone: (860) 827-0745 Fax: (860) 827-0824

Service Date: 07/20/2016

Medical Surveillance - Asbestos

Patient: Baginski, Andrzej
SSN: XXX-XX-2352
DOB: 01/02/1958
Gender: M
Marital Status: S
Address: 53 Alden St
Apt-1
NEW BRITAIN, CT 06053
Home Phone: (860) 796-1427
Work Phone: Ext.:

Job Title:
Employer: Pike Falls Corporation-West Hav
Address: 16 Hamilton St
West Haven, CT 065162300
Job Contact: Nadia Sarmiento
Role: Primary Contact
Phone: (203) 932-9639 **Ext.:**
Fax: (203) 931-8786

Race: ASIAN BLACK HISPANIC INDIAN WHITE OTHER

The above individual was seen on 07/20/2016 in accordance with: ____29 CFR 1926.1101.
____40 CFR 763.121.

The following was performed:

- ☐ Completion and review of the standardized medical questionnaire and work history with special emphasis directed to the pulmonary, cardiovascular, and gastrointestinal systems per Appendix D in 1926.1101.
- ☐ Review of the employer's description of: this employee's duties as they relate to the employee's exposure, the employee's representative or anticipated exposure level, and personal protection equipment to be utilized by the employee.
- ☐ Review of information from previous medical examinations if available.
- ☒ A physical examination with emphasis upon the pulmonary, cardiovascular, and gastrointestinal systems.
- ☐ A pulmonary function test of forced vital capacity (FVC) and forced expiratory volume at one second (FEV 1) in accordance with NIOSH and ATS standards.
- ☐ A chest roentgenogram, posterior-anterior, 14x17 inches (or current film on file) with interpretation in accordance with 29 CFR 1926.1101. (M)(2)(ii)(C).
- ☐ NOTE: According to 29 CFR 1926.1101 (M)(2)(ii)(C), it is up to the discretion of the physician whether or not a chest X-ray is required.
- ☐ The employee was informed by the physician of the results of the exam and of any medical conditions that may result from asbestos exposure including the increased risk of lung cancer attributable to the combined effect of smoking and asbestos exposure.

Unless otherwise noted below, this evaluation indicates that there are no detected medical conditions that would place the employee at an increased risk of material health impairment from exposure to asbestos, and there are no recommended limitations on the employee concerning the use of personal protective equipment or respirator.

Comments or limitations (if any): _____

K Schreers PAC
Provider Signature

7.20.16
Date

Concentra Medical Centers (CT)
972A W Main St New Britain, CT 06053
Phone: (860) 827-0745 Fax: (860) 827-0824

PLHCP[1] WRITTEN STATEMENT for RESPIRATORS (EMPLOYEE)

Service Date: 07/20/2016

Employee Name: Baginski, Andrzej

Employee SSN: XXX-XX-2352

Address:
53 Alden St
Apt-1
NEW BRITAIN CT 06053

Employer: AIG (Abatement Industries Group) FKA Pike Falls

You were evaluated in this office of your medical status related to your physical capability to wear a respirator. (Check ✓ one that applies)

- ☒ There were no abnormal findings that would hamper your ability to perform your job duties while wearing a respirator.
- ☐ The abnormal findings listed below were not related to wearing a respirator but should be reported to your personal physician for further evaluation.

_____

_____

Based upon the results of this evaluation it is my opinion that you: (Check ✓ ALL that apply)

- ☒ ARE qualified to wear a respirator.
- ☐ Have the following restrictions concerning respirator usage: _____
- ☐ ARE NOT qualified to wear a respirator.
- ☐ Require further testing by your private physician who must submit a written report of his/her findings to **Concentra Medical Centers (CT)** so that a final decision on your ability to wear a respirator can be made.
- ☐ Must wear Special prescription eye-wear needed to accommodate respirator.
- ☐ Must use an Eye glass conversion kit.
- ☐ May need to shave Facial hair to assure tight seal on certain face masks.
- ☐ Need to stop smoking.

(Check ✓ ALL that apply)

- ☒ The above individual HAS been examined for respirator fitness in accordance with 29 CFR 1910.134. This limited evaluation is specific to respirator use only. Employees should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.
- ☐ The above individual HAS NOT been examined by me for respirator fitness. The employee's medical evaluation consisted of a review of OSHA's Medical Evaluation Questionnaire in Appendix C Part A Section 2. In accordance with 29 CFR 1910.134, this limited evaluation is specific to respirator use only. Employees should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.
- ☐ In accordance with specific OSHA requirements, I have informed the above named individual of the results of this evaluation and of any medical conditions resulting from exposures that may require further explanation or treatment. Where applicable, the above named individual has been informed of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos, lead and/or other chemical exposure(s).

Respirators must be properly selected based on the containment and concentration levels to which the worker will be exposed. Failure to follow the use and fitting instruction and warnings for proper use contained on the respirator packaging and/or failure to wear the respirator during all times of exposure can reduce the respirator's effectiveness and result in sickness or death. Wearer must be trained in the proper care of any respirator.Refer to product literature and packaging for specific information regarding fit, use and/or limitations.

K Scheeran APC
PLHCP Signature

Andrzej Baginski
Employee's Signature

Scheeran
PLHCP Name (printed)

7.20.17
Expiration Date

[1]Physician or other Licensed Healthcare Professional

To be maintained in the employee's file with a copy to the employee

EasyOne™ DIAGNOSTIC 6.6
© ndd 2000-2010
SN 108884 RecNo 1452
07/20/2016 02:07pm

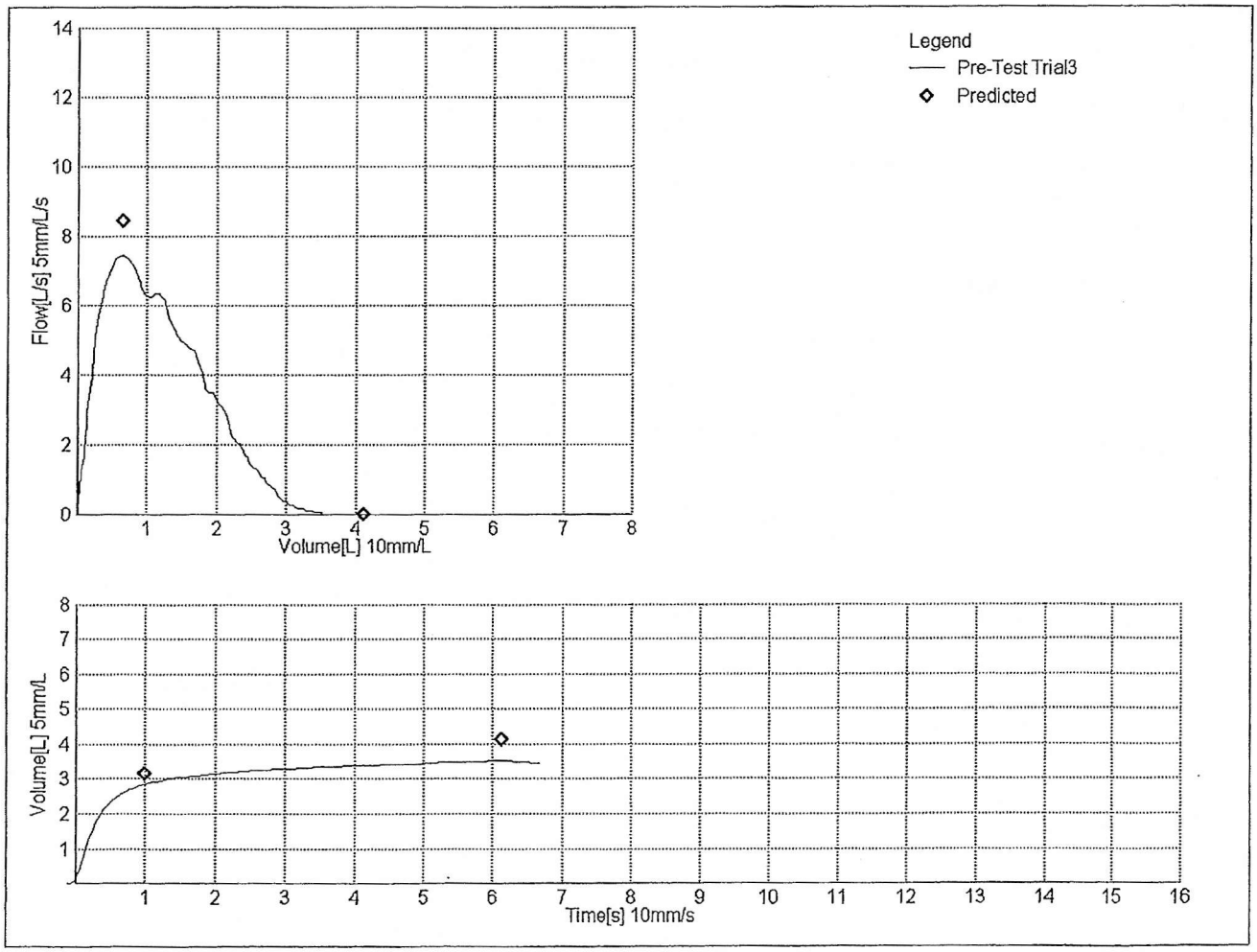
Patient Information		Test Information	
Name	ANDRZEJ	Test Date/Time	07/20/2016 02:06pm
ID	043882352	Post Time	--:--
Age	58	Test Mode	DIAGNOSTIC
Height	5 ft 6 in	Interpretation	GOLD/Hardie
Weight	205 lbs,BMI 33.3	Predicted Ref	NHANES III
Gender	MALE	Value Select	BEST VALUE
Ethnic	CAUCASIAN	Tech ID	
Smoker	YES	Automated QC	ON
Asthma	NO	BTPS (IN/EX)	-.-/ 1.02

Test Results — Your FEV1 is 91% Predicted. Your Lung Age is 66

Parameter	Pre-Test Best	Trial3	Trial1	Trial2	Pred	%Pred
FVC[L]	3.53	3.53	3.47	3.29*	4.14	85
FEV1[L]	2.87	2.87	2.77	2.71	3.15	91
FEV1/FVC[%]	81.3	81.3	80.0	82.4	76.0	107
PEF[L/min]	446.7	446.7	399.2	398.2	506.1	88
FEF25-75[L/s]	2.99	2.99	2.67	2.89	2.69	111
FET[s]	6.14	6.14	6.31	6.57	-.--	--

* Indicates Below LLN or Significant Post Change

Pre-Test Interpretation: FEV1 Var=0.10L 3.3%; FVC Var=0.06L 1.8%; Session Quality A
Normal Spirometry



Respiratory Fit Test Record

Employee Name: Andy Baginski

Social Security: 2352

Location: PIKE FALLS 16 HAMILTON STREET

WEST HAVEN CT 06516

Location if Different then Above: _____

Date Tested: 3-12-17

Type of Test: *Irritant Smoke Qualitative Testing*

Type of Respirator: *North ½ Face (7700-30 small, medium, large) circle one*

Test Results: (Pass) / Fail

Type of Respirator: *Racal PAPR (under Negative Pressure)*

Test Results: (Pass) / Fail

Other Types of Respirator: _____

Test Results: Pass / Fail

Employee Signature: _____ Date: 3-12-17

Administrator: _____ Date: 3-12-17