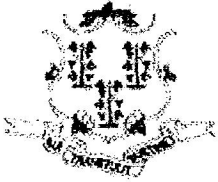


Employee Name	RORY GRAY
Current Asbestos License	11/30/2017
Current Asbestos Training	5/20/2017
Current Medical	5/27/2017
Current Respirator Fit Test	6/16/2017
Other	
10 Hour OSHA	
LEVEL III TRAINING	7/22/2017
ITC AWARENESS	7/22/2017



State of Connecticut

Lookup Detail View

Name

Name

RORY L GRAY

License Information

lookup

License Type	License Number	Expiration Date	Granted Date	License Name	License Status	Licensure Actions or Pending Charges
Asbestos Abatement Supervisor	2647	11/30/2017	06/21/2005	Rory L. Gray	ACTIVE	None

Generated on: 12/6/2016 1:30:40 PM

ENVIRONMENTAL TRAINING AND ASSESSMENT

Certificate of Completion

*Asbestos Abatement Site Supervisor
Initial Training Course
Awarded To*

Rory L Gray
140 Christine Drive
East Hartford, CT 06108

Has successfully completed, and passed an examination covering the contents of the initial five (5) day 40 Hour Training Course for Asbestos Abatement Site Supervisor. 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: 5/16/2016 Through 5/20/2016

Examination Grade: 87%

Examination Date: 5/20/2016

Certificate Number:

ASI-00740

Expiration Date: 5/20/2017

Boston Lead Company, LLC

dba

Environmental Training and Assessment

62 Washington Street

Middletown, CT 06457

860-347-7277

Refresher Date Due: 03/20/2016

Stephen J. Craig, Training Manager

Concentra Medical Centers (CT)

370 James St Suite 304 NEW HAVEN, CT 06513
Phone: (203) 503-0482 Fax: (203) 503-0492

EMPLOYER AUTHORIZATION AND INFORMATION FOR RESPIRATORY EVALUATION**EMPLOYER TO COMPLETE THE FOLLOWING :**Employee Name: Gray, Rory L.Employer: AIG (Abatement Industries Group) FKA Pike Falls**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
☐ Continuous-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: _____

Questionnaire will be: ☐ HAND CARRIED ☐ MAILED ☐ OTHER

Address:

3 Sharon AveWEST HAVEN CT 06516Employee SSN: XXX-XX-5035**Extent of Usage (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

PLHCP¹ 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 separate forms, in separate 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 Professional² 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).

Physician's Signature

Physician's License Number (Optional in Most States)

Physician's Name (Printed)

Date of Exam

Expires On

Patient:	Gray, Rory L.
SSN:	XXX-XX-5035
DOB:	11/09/1983
Gender:	M
Marital Status:	S
Address:	3 Sharon Ave
	WEST HAVEN, CT 06516
Home Phone:	(860) 713-8436
Work Phone:	Ext.:

Job Title: _____
Employer: Pike Falls-Abatement Ind _____
Address: 16 Hamilton St _____

 West Haven, CT 065162300 _____
Job Contact: Monica Giannetta _____
Role: Primary Contact _____
Phone: (203) 932-9639 **Ext.:** _____
Fax: (203) 931-8786 _____
Race: ASIAN BLACK HISPANIC IND _____

The above individual was seen on 05/27/2016 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): _____

W. H. P. H.

Provider Signature

507116

Date _____

Concentra Medical Centers (CT)

370 James St Suite 304 NEW HAVEN, CT 06513
Phone: (203) 503-0482 Fax: (203) 503-0492

PLHCP¹ WRITTEN STATEMENT for RESPIRATORS (EMPLOYEE)

Service Date: 05/27/2016

Employee Name: Gray, Rory L.

Employee SSN: XXX-XX-5035

Address:

3 Sharon Ave

WEST HAVEN CT 06516

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.


PLHCP Signature

Kristen Kinslaw
PLHCP Name (printed)

¹Physician or other Licensed Healthcare Professional

Employee's Signature

5/27/17
Expiration Date

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

Patient Information

Name GRAY
 ID 045765035
 Age 32
 Height 5 ft 7 in
 Weight 213 lbs, BMI 33.4
 Gender MALE
 Ethnic CAUCASIAN
 Smoker NO
 Asthma YES

Test Information

Test Date/Time 05/27/2016 03:32pm
 Post Time ---
 Test Mode DIAGNOSTIC
 Interpretation GOLD/Hardie
 Predicted Ref Knudson83
 Value Select BEST VALUE
 Tech ID
 Automated QC ON
 BTPS (INEX) -- 1.02

Test Results

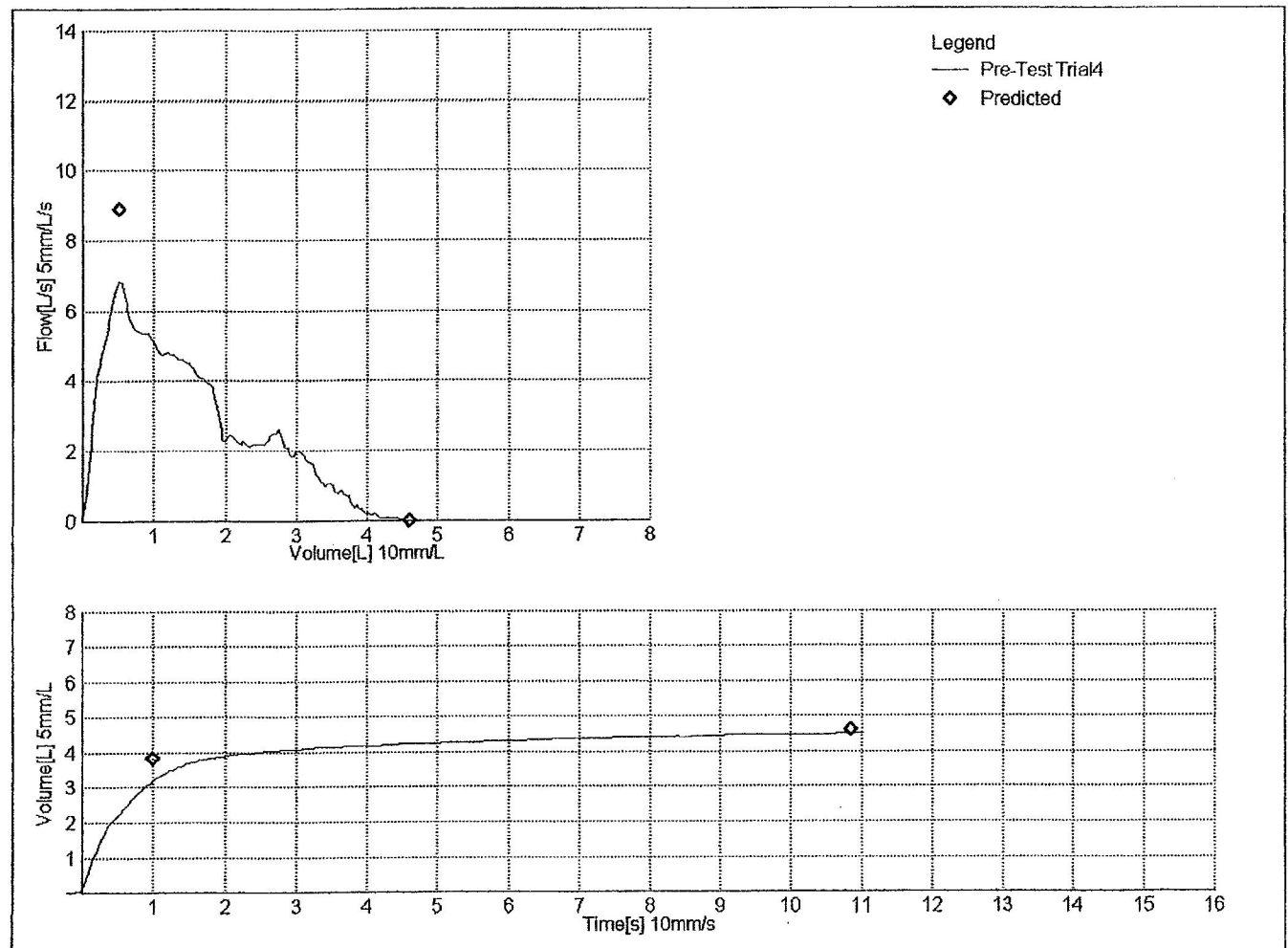
Your FEV1 is 83% Predicted

Parameter	Pre-Test					
	Best	Trial4	Trial3	Trial1	Pred	%Pred
FVC[L]	4.51	4.51	4.40	4.11	4.61	98
FEV1[L]	3.22	3.22	2.99*	2.98*	3.86	83
FEV1/FVC[%]	71.4*	71.4*	67.8*	72.4	83.3	86
PEF[L/min]	411.9*	411.9*	335.1*	319.1*	532.0	77
FEF25-75[L/s]	2.42	2.42	2.08*	2.28*	4.16	58
FET[s]	10.84	10.84	10.98	8.47	--	--

* Indicates Below LLN or Significant Post Change

Pre-Test FEV1 Var=0.23L 7.2%; FVC Var=0.10L 2.3%; Session Quality D
 Interpretation Normal Spirometry
 Caution: Maneuvers Not Reproducible - Interpret With Care.

JK
 5/27/16



Respiratory Fit Test Record

Employee Name: Rory Gray

Social Security: 5035

Location: PIKE FALLS 16 HAMILTON STREET

WEST HAVEN CT 06516

Location if Different then Above: _____

Date Tested: 6-16-16

Type of Test: Irritant Smoke Qualitative Testing

Type of Respirator: North 1/2 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: [Signature] Date: 6-16-16

Administrator: Chris Powers Date: 6-16-16