ESSG Medical Referral to Employer

Employee Name: _____ **Date of Injury:** _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Health Care Provider who completes this form to release any information to The Suzlon Rotor Corporation which substantiates, clarifies, or elaborates on my fitness for duty.

_____ _____
Employee Signature Date

Medical Provider _____ **Date / Time of Appt:** _____

ALL WORKERS' COMPENSATION MEDICAL EXPENSES must include the patient name, date of service, and Medical Provider's "Progress Notes" for treatment. Social Security Number is recommended. Mail all claims for payment directly to:

ESSG
7300 Metro Blvd
Ste. 635
Edina, MN 55439
(952)835-1288
Fx: (952)835-1255

Diagnosis: _____ _____ **Non-work related**

_____ _____ **Undetermined**

Treatment Plan: _____ _____ **Work related**

RETURN TO WORK: _____ **With No Limitations** **Date:** _____
(Suzlon rotor Corp. has an active return-to-work program. Most temporary restrictions can be accommodated. Please call 507-562-6700 if you have any questions regarding light duty jobs.)

_____ **TOTALLY DISABLED:** (Dates) From: _____ To: _____

_____ **RESTRICTED WORK:** **Duration of Limitations:** _____ Days/Weeks

_____ Restricted Work Hours: May Work _____ hours per day _____ hours per week.
_____ Restricted Lifting: Maximum lift: _____10lbs _____20lbs _____30lbs _____40lbs _____50lbs
Weight limit for repetitive lifting or carrying: (more frequent than 2 times per hour)
_____ 0-5lbs _____ 5-10lbs _____ 10-20lbs _____ 20-30lbs _____30-40
_____ Restricted bending: (Limit in degrees) _____ Bending frequency (# of times per hour): _____
_____ Restricted use of hand: ___ Right ___Left ___ No Use or ___ Limited repetitive grasping, gripping
_____ Standing/Sitting: Standing (hours per day) _____ Sitting (hours per day) _____
_____ Other: _____

Next Appt. Date / Time: _____ **Provider's Comments:** _____

_____

Medical Provider Signature: _____ **Date:** _____

Please fax back form to 507.562.6800 – Attn CMG/ESSG