

Health Care Provider Report

See Instructions on Reverse Side
(WHEN COMPLETED RETURN TO REQUESTER)



HC01

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER 475118768	DATE OF INJURY 6-26-08	DOB 3-5-78
EMPLOYEE Brian Erhternash	EMPLOYER Suzlon Kator	
INSURER/SELF-INSURER/TPA	INSURER CLAIM NUMBER	
INSURER ADDRESS		
CITY	STATE	ZIP CODE

REQUESTER must specify all items to be completed by health care provider. Items: _____ MMI (#9) PPD (#10)
HEALTH CARE PROVIDER TO COMPLETE ITEMS REQUESTED ABOVE

- Date of first examination for this injury by this office: (date)
- Diagnosis (include all ICD-9-CM codes):
- History of injury or disease given by employee:
- In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? No Yes
- Is there evidence of pre-existing or other conditions that affect this disability? No Yes If yes, describe:
- Is further treatment of this injury or referral to another doctor planned? No Yes If yes, describe:
- Has surgery been performed? No Yes If yes, date and describe: (date)
- Attach the most recent Report of Work Ability. Date of report: (date)
- Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) No Yes Date reached:
- Has the employee sustained any permanent partial disability from the injury? No Yes Too early to determine
The permanent partial disability is % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

NAME (Type or Print) BRUCE W KOCOUREK, DO	SIGNATURE 		DEGREE
ADDRESS PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	STATE	LICENSE #/REGISTRATION #	
CITY UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #	DATE SIGNED 6/27/08

Report of Work Ability

See Instructions on Reverse Side



RW01

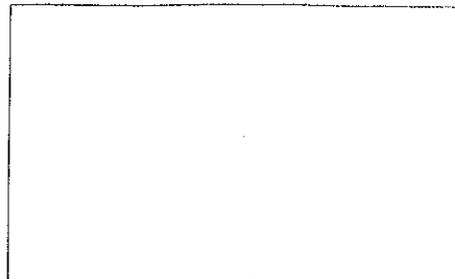
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

This form must be provided to the employee.
(Minn. Rules 5221.0410, subp. 6)

DO NOT USE THIS SPACE

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

SOCIAL SECURITY NUMBER 475-118768	DATE OF INJURY 6-27-08
EMPLOYEE BRIAN ECHTERNACH	Date of Birth 3-5-78
EMPLOYER Suzelan Kotar	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	



Date of most recent examination by this office 6-27-08 (date)

Select the appropriate option(s) below and fill in the applicable dates.

1. Employee is able to work without restrictions as of 6/30/08 (date)
2. Employee is able to work with restrictions, from _____ (date) to _____ (date)

The restrictions are:

3. Employee is unable to work at all, from 6/27/08 (date) to 6/29/08 (date)

The next scheduled visit is: as needed OR _____ (date)

NAME (Type or Print) BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER ADD 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 CITY UPIN D25406 NPI 1699738559	SIGNATURE <i>B. Kocourek</i>	DEGREE	
	STATE	LICENSE #/REGISTRATION #	
DE	AREA CODE	TELEPHONE #	DATE SIGNED