



Medical Referral to Employer

Employee Name: Brittany Hoisington Date of Injury: 5-8-08

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:
**Berkley Risk
PO BOX 59143
Minneapolis, MN 55459-0413
(612)766-3000**
Incomplete billings or those mailed directly to Corporate Management Group may result in slow payment processes.

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: 4 days 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: B. Paramo Date: 5/8/08

Health Care Provider Report

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

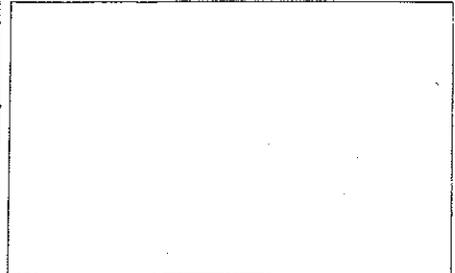


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Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER <i>504171167</i>	DATE OF INJURY <i>5-8-08</i>	DOB <i>11-1-89</i>
EMPLOYEE <i>Brittany Hoisington</i>	EMPLOYER <i>Suzlon Kotey</i>	
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

1. Date of first examination for this injury by this office: (date)
2. Diagnosis (include all ICD-9-CM codes):
3. History of injury or disease given by employee:
4. 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
5. Is there evidence of pre-existing or other conditions that affect this disability? No Yes If yes, describe:
6. Is further treatment of this injury or referral to another doctor planned? No Yes If yes, describe:
7. Has surgery been performed? No Yes If yes, date and describe: (date)
8. Attach the most recent Report of Work Ability. Date of report: (date)
9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) No Yes Date reached:
10. 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:

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NAME (Type or Print) BRUCE W KOCOUREK, DO	SIGNATURE <i>B. Kocourek</i>	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 <i>5/8/08</i>

Report of Work Ability

See Instructions on Reverse Side



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DO NOT USE THIS SPACE

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)

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 504 171167	DATE OF INJURY 5-8-08
EMPLOYEE Brittany Hoisington	Date of Birth 11-1-89
EMPLOYER Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office

5-8-08 (date)

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

1. Employee is able to work without restrictions as of

(date)

2. Employee is able to work with restrictions, from

5/5/08 (date)

to

5/12/08 (date)

The restrictions are:

no use @ hand

3. Employee is unable to work at all, from

(date)

to

(date)

The next scheduled visit is: as needed

OR

5/12/08 (date)

NAME (Type or Print) BRUCE W KOCOUREK, DO	SIGNATURE B. Kocourek	DEGREE
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		DATE SIGNED 5/5/08