Medical Referral to Employer

Employee Name: Bruce Komula **Date of Injury:** 12-3-07

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 Larry D. Christensen **Date / Time of Appt:** 12-4-07 / 1:40

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: Left Knee Pain

Treatment Plan: Avoid pain

____ **Non-work related**

____ **Undetermined**

____ **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: _____

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

____ Restricted Work Hours: May Work _____ hours per day _____ hours per week.

X Restricted Lifting: Maximum lift: _____10lbs ___X___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) _____

X Other: Avoid activity that causes left knee pain

Next Appt. Date / Time: 1 wk **Provider's Comments:** _____

Medical Provider Signature: _____ **Date:** 12-4-07

Please fax back to 507.562.6800 – Attn CMG.

3 PART DRUGS OF ABUSE TEST REQUEST

MEDTOX® LABORATORIES, INC.

SPECIMEN ID V8521908

Account #

Employer:
SUZLON ROTOR CORPORATION
1711 S HWY 75
PIPESTONE, MN 56164

MRO:

Account # 93470

STEP 1 To be completed by **COLLECTOR / DONOR**

Social Security No, Employee No. or other Identification No.

Donor I.D. 082780600

Specimen Type: ☐ Blood ☒ Urine ☐ Oral Fluid

Donor Name (last, first) or SSN: KOMULA BRUCE

Donor Daytime Phone: 5072151809

Referring Phys. / Company: CMC

DONOR CONSENT *I certify that I provided my specimen to the collector, that the specimen container was sealed with a tamper-proof seal in my presence; and that the information provided on this form and on the label affixed to the specimen bottle is correct. I authorize MEDTOX to release the results of the tests to my employer, prospective employer, employer representative and/or their authorized healthcare professionals.*

Signature

DATE Month Day Year: 12 06 2007

Test(s) Ordered: ☒ 88543 7 PANEL

STEP 2 To be Completed by **COLLECTOR**

Indicate Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion ☐ Other (specify): ☐ Return to Duty ☐ Follow-up ☒ Post Accident ☐ Periodic Medical

STEP 3 To be Completed by **COLLECTOR**

▶Specimen temperature must be read within 4 minutes of collection

Specimen Temperature within range: (90°-100°F/32°-38°C) ☒ YES ☐ No, Remark Required

81605

STEP 4 To be Completed by **COLLECTOR**

Collection Site Location: *Facility and Address* 481
PIPESTONE COUNTY MED CENTER
PIPESTONE, MN 56164

Collection Site Phone No.: (507) 825-5811

Fax No.: (507) 825-6081

Date and Time of Collection: Month Day Year 12 06 2007 DATE; Hour Minutes 1500 TIME; ☐ am ☒ pm

Remarks Concerning Collection

I, the collector, by signing below certify that the specimen identified on this form is the specimen given to me by the donor identified above and that it has been collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X Debra Grootwassink
Signature of Collector

Debra A. Grootwassink
(PRINT) Collector's Name (First, MI, Last)

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab

☒ DHL ☐ Local Courier ☐ Other

STEP 5

12 06 07

Report of Work Ability

See Instructions on Reverse Side

RW01

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	DATE OF INJURY 12/4/07
EMPLOYEE ~~Suzlon~~ Bruce Komula	Date of Birth 10/3/87
EMPLOYER Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 12/6/07 (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 12-6-07 (date) to _____ (date)

The restrictions are:

Avoid activity that causes left knee pain

3. ☐ Employee is unable to work at all, from _____ (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____ (date) 1 wk

NAME (Type or Print)	SIGNATURE	DEGREE
LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP		MD
ADDRESS 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 FAX 507-825-4744 DEA-AC7916539 MN LISC-23799 UPIN D75623	STATE	LICENSE #/REGISTRATION #
CITY E	AREA CODE / TELEPHONE #	DATE SIGNED 12-06-07

MN RW01 (7/01)