



1661 St Anthony Ave
 Saint Paul, MN 55104-7633
 Phone: 651-968-5300 Fax: 651-646-0205

REPORT OF WORKABILITY

Date 09/17/2014 Appointment Time 09:00

Employee Ruth Ogud

Patient ID XXX-XX-4993 DOB 01/01/1971 DOI 09/15/2014 MCO _____

MO DAY YR MO DAY YR

Employer Corporate Management Group

Contact person Dan Zezza Fax # _____

Diagnosis R. lower leg contusion & ankle sprain

Work related Not work related Undetermined
 Permanent Disability? Likely Not likely Undetermined
 MMI? No Yes If yes, give date _____

ART _____
 TI _____
 TO _____
 Employer Contacted?
 Yes No
 Faxed Phoned

Return to work with no limitations on ____/____/____
 Return to work with limitations on 9-17-14 through 9-24-14
 Unable to work from ____/____/____ through ____/____/____

Avoid the following hand and wrist activities

	Left	Right	Both
Operate power/vibrating tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coarse manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Torquing/crimping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping-light/heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoid use of hand(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-stretched arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No operating forklift			
<input type="checkbox"/> No operating machinery			
<input type="checkbox"/> No driving motor vehicle			

EMPLOYEE'S RESTRICTIONS

	NOT AT ALL	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%		NOT AT ALL	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%
Lift/Carry:					Bend				
0-10 lbs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ degrees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist/Turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneel/Squat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Push/Pull:					Stand/Walk	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-25 lbs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overhead Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ladder/Stair Climb	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-75 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rotate Activities/Positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76-100 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

- Lift with palms up
- Change positions as needed
- Lift from mid thigh to mid chest

COMMENTS/TREATMENT:

3x day - 15-20 min

- Keep wound clean and dry. Change dressing every _____ First Aid
- Medication Ibuprofen - 3x day Over Counter Meds
- Ice Heat Elevate Splint/Brace Crutches Head injury sheet Wound care sheet given
- Physical Therapy
- Specialist Referral
- Return to Clinic on one week Date 9-23-14 Time 9:30am

The above has been discussed with the employee.

Signature [Signature]
 Date 9-23-14 Time 9:30am
 John Kipp, MD Physician