



A member of Avera McKeaney Primary Care Network

508 10th Street
Worthington, MN 56187-2343
(507) 372-2921
1-800-881-1473
Fax (507) 372-5789

Confidential Facsimile
Cover Sheet

Date: 5/28/08

Time: 9:45

Number of Pages (including cover sheet): 2

TO: Ashley
(authorized receiver's name and/or department)
Suzlon
(authorized receiver's facility name)

Telephone: _____
(authorized receiver's number)

Fax: 507-562-6800
(authorized receiver's fax number)

FROM: Sandy Manager P.S.
(sender's name and department)
Avera Worthington Specialty Clinics
508 10th Street
Worthington, MN 56187-2343

- Telephone: (507) 372-1840 Internal Medicine Fax: (507) 372-1850
- Telephone: (507) 372-1820 Family Practice Fax: (507) 372-1825
- Telephone: (507) 372-1870 Lab Department Fax: (507) 372-1906
- Telephone: (507) 372-1880 OB/GYN Fax: (507) 372-1884
- Telephone: (507) 372-1890 Pediatrics Fax: (507) 372-1899
- Telephone: (507) 372-1900 Surgery Fax: (507) 372-1825
- Telephone: (507) 372-1930 or 1935 X-Ray Fax: (507) 372-1934
- Telephone: (507) 372-¹⁹⁴⁶815 Business Office Fax: (507) 372-1815
- Telephone: (507) 372-1925 Facility Services/Central Supply Fax: (507) 372-1915

COMMENTS: Hi Ashley,
Attached is the we form on Christopher Dawood
Have a Good Day Sandy



Medical Referral to Employer

Employee Name: Christopher Dawood Date of Injury: 5/2/08

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 Richard Sudmeier MD Date / Time of Appt: 5/13/08

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: LACERATION @ hand Non-work related

Treatment Plan: Suture Undetermined Work related

RETURN TO WORK: With No Limitations Date: 5/14/08
(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: [Signature] Date: 5/27/08

Please fax back to 507.562.6800 - Attn CMG.