



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

# REPORT OF WORKABILITY

Date 10/21/2014 Appointment Time 13:00

Employee Jeffrey C. Fennern

Patient ID XXX-XX-2875 DOB 04/18/1966 DOI 10/19/2014 MCO \_\_\_\_\_  
MO DAY YR MO DAY YR

Employer Corporate Management Group

Contact person Dan Zezza Fax # \_\_\_\_\_

Diagnosis R knee pain, R shoulder pain, R forearm contusion/laceration

- Work related      Permanent Disability?       Likely     Not likely     Undetermined
- Not work related
- 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 10/21/14 through \_\_\_\_/\_\_\_\_/\_\_\_\_
- Unable to work from \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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%
<b>Lift/Carry:</b>					Bend _____ degrees				
0-10 lbs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist/Turn	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input 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"/>
21-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stand/Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Push/Pull:</b>					Overhead Reaching <u>(R)</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-25 lbs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ladder/Stair Climb <u>(R)</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 lbs	<input 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"/>
51-75 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
76-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Avoid the following hand and wrist activities**

	Left	Right	Both
Operate power/vibrating tools	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coarse manipulation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Torquing/crimping	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Grasping-light/heavy	<input type="checkbox"/>	<input checked="" 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"/>

No operating forklift  
 No operating machinery  
 No driving motor vehicle

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

COMMENTS/TREATMENT: No overhead lifting/reaching with R arm.

watch for signs of infection

- Keep wound clean and dry. Change dressing every \_\_\_\_\_  First Aid
- Medication Tylenol deltas booster  Over Counter Meds
- Ice  Heat  Elevate knee sleeve  Splint/Brace  Crutches  Head injury sheet  Wound care sheet given
- Physical Therapy
- Specialist Referral
- Return to Clinic on one week.

Date 10/30/14 Time 2 PM

The above has been discussed with the employee.

Signature S. Richner  
 Susan Richner, MD physician