F A X S H E E T

Date:	Mar-24-2017 02:09:38
To:	Employer Solutions Staffing Group
Subject:	Patient Document
Fax Number:	952-767-0740
To Company:	Employer Solutions Staffing Group
From Name:	Thiede,Sharon
From Company:	MedSpring
From Facility:	MedSpring
Support Contact:	
Number of Pages(s):	4

Employee- You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado- Es necesario que reporte su lesion a su empleador dentro de 30 dias a partir de la fecha en que se lesiono si es que su empleador cuenta con un seguro de compensacion para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la Division de Compensacion para Trabajadores, y tambien puede tener derecho a ciertos beneficios medicos y monetarios. Para mayor informacion comuniquese con la oficina local de la Division al telefono 1-800-252-7031

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART 1: GENERAL INFORMATION		5. Doctor's Name And Degree Douglas L Kehres, MD	(for transmission purposes only)	Date Being Sent 03/23/2017
1. Injured Employee's Name: George Lee V Deihl		6. Clinic / Facility Name MedSpring-DFW-Keller	9. Employer's Name: Employer Solutions Staffing Group	
2. Date of Injury: 03/17/2017	3. Social Security Number (Last 4 Digits): XXX-XX-0000	7. Clinic / Facility / Doctor Phone & Fax 214-295-9385 682-593-7029	10. Employer's Fax # or Email Address: 952-767-0740	
4. Employee's Description of Injury / Accident: cut forearm on glass at work		8. Clinic / Facility / Doctor Address (street address): 104 S MAIN ST	11. Insurance Carrier: NONE	
		City: KELLER State: TX Zip 76248-4950	12. Carrier's Fax# or Email Address (if known)	

PART II: WORK STATUS INFORMATION

(FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☑ (a) will allow the employee **to return to work** as of 03/23/2017 **without restrictions.**

☐ (b) will allow the employee **to return to work** as of **with restrictions identified in PART III,** which are expected to last through

☐ (c) has prevented and still prevents the employee **from returning to work** as of and is expected to continue through .

The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS*

(ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	
Kneeling / Squatting	☐	☐	☐	☐	☐	
Bending / Stooping	☐	☐	☐	☐	☐	
Pushing / Pulling	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	
Climbing stairs / ladders	☐	☐	☐	☐	☐	
Grasping / Squeezing	☐	☐	☐	☐	☐	
Wrist flexion / extension	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Overhead Reaching	☐	☐	☐	☐	☐	
Keyboarding	☐	☐	☐	☐	☐	
Other:						

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work:
☐ Sit / Stretch breaks of per
☐ Must wear splint / cast at work
☐ Must use crutches at all times
☐ No driving / operating heavy equipment
☐ Can only drive automatic transmission
☐ No work / hours / day work: ☐ in extreme hot / cold environments ☐ at heights or on scaffolding
☐ Must keep ☐ elevated ☐ clean & dry
☐ No skin contact with:
☐ Dressing changes necessary at work
☐ No running

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ Left Hand / Wrist ☐ Left leg
☐ Right Hand / Wrist ☐ Right leg
☐ Left Arm ☐ Back
☐ Right Arm ☐ Left Foot / Ankle
☐ Neck ☐ Right Foot / Ankle
Other:

18. LIFT CARRY RESTRICTIONS (if any):

☐ May not lift / carry objects more than lbs. for more than hours per day
☐ May not perform any lifting / carrying
Other:

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)
☐ Advised to take over-the counter meds
☐ Medication may make drowsy (possible safety / driving issues)

16. OTHER RESTRICTIONS (if any):

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT FOLLOW-UP APPOINTMENT INFORMATION

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on at :
☐ Referral to / consult with on at :
☐ Physical medicine X per week for weeks starting on at :
☐ Special studies (list): on at :
☑ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

21. Work Injury Diagnosis Information:

Forearm laceration, right, S51.811D

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role Of Doctor:
03/23/2017			☐ Initial	☐ Designated doctor ☐ Carrier-selected RME
Discharge Time			☑ Follow-up	☑ Treating doctor ☐ DWC-selected RME
615pm				☐ Referral doctor ☐ Other Doctor
				☐ Consulting doctor

DIVISION OF WORKERS COMPENSATION

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 * MS-94
Austin, TX 78744-1645
(800) 252-7031 phone * (512) 490-1047 fax

Complete if known:
DWC Claim #
Carrier Claim #

REPORT OF MEDICAL EVALUATION

I. GENERAL INFORMATION	4. Injured Employee's Name (First, Middle, Last) George Lee V Deihl		9. Certifying Doctor's name and License Type Douglas L Kehres, MD
1. Workers' Compensation Insurance Carrier	5. Date of Injury	6. Social Security Number XXX-XX-0000	10. Certifying Doctor's License Number and Jurisdiction Q5835
2. Employer's Name Employer Solutions Staffing Group	7. Employee's Phone Number 719-964-1399		11. Certifying Doctor's Phone and Fax Numbers 214-295-9385 682-593-7029
3. Employer's Address (Street or PO Box, City State Zip) 7301 Ohms Lane, Ste 405 Edina MN 55439	8. Employee's Address (Street or PO Box, City State Zip) 14137 Tanglebrush Tri Haslet TX 76052-3356		12. Certifying Doctor's Address (Street or PO Box, City State Zip) 104 S MAIN ST TX 76248-4950

II. DOCTOR'S ROLE

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI / impairment and file this report [28 Texas Administrative Code (TAC) §130.1 governs such authorization]:

☐ Treating Doctor ☐ Doctor selected by Treating Doctor acting in place of the Treating Doctor ☐ Designated Doctor selected by DWC

☐ Insurance Carrier-selected RME Doctor approved by DWC to evaluate MMI* and / or permanent impairment after a Designated Doctor examination.

NOTE: If you are not authorized by 28 TAC §130.1 to file this report, you will not be paid for this report or the MMI / impairment examination.

III. MEDICAL STATUS INFORMATION

14. Date of Exam 03/23/2017 15.Diagnosis Codes S51.811D

16.Indicate whether the employee has reached Clinical or Statutory MMI based upon following definitions:

Clinical Maximum Medical Improvement (Clinical MMI) is the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Statutory MMI is the later of: (1) the end of the 104th week after the date that temorary income benefits (TIBs) began to accrue; or (2) the date to which MMI was extended by DWC pursuant to Texas Labor Code §408.104.

a) ☑ Yes, I certify that the employee reached ☐ STATUTORY / ☑ CLINICAL (mark one) MMI on 03/23/2017 (may not be a prospective date) and have included documentation relating to this certification in the attached narrative. - OR -

b) ☐ No, I certify that the employee has NOT reached MMI but is expected to reach MMI on or about

The reason the employee has not reached MMI is documented in the attached narrative.

NOTE: The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

IV. PERMANENT IMPAIRMENT

17. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury. "Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be made based upon objective clinical or laboratory findings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

a) ☑ I certify that the employee does not have any permanent impairment as a result of the compensable injury. - OR -

b) ☐ I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is %, which was determined in accordance with the requirements of the Texas Labor Code and Texas Administrative Code. The attached narrative provides explanation and documentation used for the calculation of the impairment rating assigned using the appropriate tables, figures, or worksheets from the following edition of the *Guides to the Evaluation of Permanent Impairment* published by the American Medical Association (AMA):

☐ third edition, second printing, February 1989 - OR -

☐ fourth edition, 1st , 2nd , 3rd , or 4th printing, including corrections and changes issued by the AMA prior to May 16, 2000.

NOTE: A finding of no impairment is not equivalent to a 0% impairment rating. A doctor can only assign an impairment rating, including a 0% rating, if the doctor performed the examination and testing required by the AMA Guides.

V. DOCTOR'S CERTIFICATION

18. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Labor Code and applicable rules. If an impairment rating has been assigned, I certify that I have completed the required trianing and testing and have a current certification by DWC to assign impairment ratings in the Texas workers' compensation system or have received specific permission by DWC to certify MMI and assign an impairment rating. I understand that making a misrepresentation about a workers' compensation claim or myself is a crime that can result in fines and / or imprisonment and nullification of this report.

Signature of Certifying Doctor:

Date of Certification: 03/23/2017

VI. TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION

19. Treating Doctor's Name and License Type	22. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's certification of MMI.
20. Treating Doctor's License Number and Jurisdiction	23. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's finding of no

21. Treating Doctor's Phone and Fax Numbers	Impairment - OR - ☐ I AGREE / ☐ I DISAGREE with the impairment rating assigned by the certifying doctor.

24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and / or imprisonment.

Signature Of Treating Doctor: Date/Time: