Report of Work Ability

See Instructions on Reverse Side

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)

RW01

DO NOT USE THIS SPACE

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 1-30-08
EMPLOYEE John Hemminger	Date of Birth 10-23-81
EMPLOYER CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 1-31-08 (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 1/31/08 (date) to 2/2/08 (date)

The restrictions are:

maximal protection, limit resin exposure

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

The next scheduled visit is: ☒ as needed OR _____ (date)

NAME (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONECOUNTY MEDICAL CENTER ADDRES 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 CITY UPIN D25406 NPI 1699738559	B Kocourek	
	STATE	LICENSE #/REGISTRATION #
	AREA CODE	TELEPHONE # / DATE SIGNED 1-31-08

MN RW01 (7/01)

Health Care Provider Report

See Instructions on Reverse Side
(WHEN COMPLETED RETURN TO REQUESTER)

HC01

DO NOT USE THIS SPACE

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
	1-30-08	10-23-81
EMPLOYEE John Hemminger	EMPLOYER CMG	
INSURER/SELF-INSURER/TPA	INSURER CLAIM NUMBER	
INSURER ADDRESS		
CITY STATE ZIP CODE		

REQUESTER must specify all items to be completed by health care provider. ☐ Items: _____ ☐ MMI (#9) ☐ PPD (#10)

HEALTH CARE PROVIDER TO COMPLETE ITEMS REQUESTED ABOVE

1. Date of first examination for this injury by this office: 1-31-08 (date)

2. Diagnosis (include all ICD-9-CM codes):
contact dermatitis poisons

3. History of injury or disease given by employee:
rash c exposure to resins @ work

4. In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? ☐ No ☑ Yes

5. Is there evidence of pre-existing or other conditions that affect this disability? ☑ No ☐ Yes If yes, describe:

6. Is further treatment of this injury or referral to another doctor planned? ☑ No ☐ Yes If yes, describe:

7. Has surgery been performed? ☑ No ☐ Yes If yes, date and describe: (date)

8. Attach the most recent Report of Work Ability. Date of report: 1/31/08 (date)

9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) ☑ No ☐ Yes Date reached:

10. Has the employee sustained any permanent partial disability from the injury? ☐ No ☐ Yes ☑ Too early to determine
The permanent partial disability is % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

NAME BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER	SIGNATURE B. Kocourek DO		DEGREE
ADDRESS 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	STATE	LICENSE #/REGISTRATION #	
CITY UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #	DATE SIGNED 1-31-08

MN HC01 (7/01).

ESSG Medical Referral to Employer

Employee Name: John Hemminge **Date of Injury:** 1-30-08

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.

John Hemminge
Employee Signature

Date

Medical Provider Bruce Kocourek DO **Date / Time of Appt:** 1/31/08 11:30

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:

ESSG
7300 Metro Blvd
Ste. 635
Edina, MN 55439
(952)835-1288
Fx: (952)835-1255

Diagnosis: contact dermatitis forearms ____ Non-work related ____ Undetermined ____ Work related

Treatment Plan: Medrol dosepak, Zyrtec

RETURN TO WORK: ____ **With No Limitations** **Date:** 1/31/08

(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:** 2 Days/Weeks

____ Restricted Work Hours: May Work 10 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) _____
X Other: maximal protection, avoidance of resin contact c skin

Next Appt. Date / Time: _____ **Provider's Comments:** may x 2d. return to total duties in 3 days 2/3/08

Medical Provider Signature: B. Kocourek DO **Date:** 1-31-08

Please fax back form to 507.562.6800 – Attn CMG/ESSG