

Health Care Provider Report

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

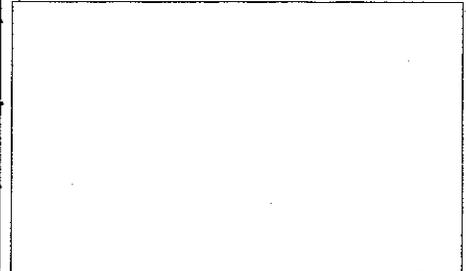


HC01

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

DO NOT USE THIS SPACE

| | | |
|---|----------------------------------|----------------------|
| SOCIAL SECURITY NUMBER <i>584 941824</i> | DATE OF INJURY <i>1-28-08</i> | DOB <i>9-7-71</i> |
| EMPLOYEE <i>Juan Gonzalez</i> | EMPLOYER <i>CMG</i> | |
| 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

- Date of first examination for this injury by this office: *1-28-08* (date)
- Diagnosis (include all ICD-9-CM codes):
blepharitis / conjunctivitis bilateral eyes *prescribed
saw/steroid*
- History of injury or disease given by employee:
resin into eyes - perspiration from forehead
- 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
- Is there evidence of pre-existing or other conditions that affect this disability? No Yes If yes, describe:
- Is further treatment of this injury or referral to another doctor planned? No Yes If yes, describe:
- Has surgery been performed? No Yes If yes, date and describe: _____ (date)
- Attach the most recent Report of Work Ability. Date of report: *1/28/08* (date)
- Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) No Yes Date reached: _____
- 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 (Type or Print) BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER ADD 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 CITY UPIN D25406 NPI 1699738559 | SIGNATURE <i>B. Kocourek</i> | DEGREE | |
| | STATE | LICENSE #/REGISTRATION # | |
| | DE | AREA CODE | TELEPHONE # |
| | DATE SIGNED <i>1/28/08</i> | | |

Report of Work Ability

See Instructions on Reverse Side



R W 0 1

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)

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 584941824 | DATE OF INJURY 1-28-08 |
| EMPLOYEE B Juan Gonzalez | Date of Birth CMG |
| EMPLOYER CMG | |
| INSURER/SELF-INSURER/TPA | |
| INSURER CLAIM NUMBER | |

Date of most recent examination by this office

1-28-08 (date)

Select the appropriate option(s) below and fill in the applicable dates.

1. Employee is able to work without restrictions as of

11/29/08 (date)

2. Employee is able to work with restrictions, from

(date)

to

(date)

The restrictions are:

3. Employee is unable to work at all, from

(date)

to

(date)

The next scheduled visit is: as needed

OR

(date)

| | | | | | | | | |
|---|------|-------|-----------|-------------|---------------------------|--------|--------------------------|------------------------|
| NAME BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559 | CITY | STATE | AREA CODE | TELEPHONE # | SIGNATURE B. Rasmussen | DEGREE | LICENSE #/REGISTRATION # | DATE SIGNED 1/25/08 |
|---|------|-------|-----------|-------------|---------------------------|--------|--------------------------|------------------------|