



Medical Referral to Employer

Employee Name: Larry G. Mohr Date of Injury: 5-5-08

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.

Larry G. Mohr Employee Signature 5-5-08 Date

Medical Provider H. Thorsen Date / Time of Appt: 5/5/08 9:45

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: Allergic Dermatitis Non-work related
 Undetermined

Treatment Plan: Medications (Cream, Pills) Work related

RETURN TO WORK: With No Limitations Date: _____
(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: pn Provider's Comments: _____

Please have arms covered / protected.

Medical Provider Signature: Heidi Thorsen Date: 5/5/08

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	DATE OF INJURY	DOB 3-24-63
EMPLOYEE Larry Mohr	EMPLOYER Sozlon	
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: 5/5/08 (date)
- Diagnosis (include all ICD-9-CM codes):
Allergic Dermatitis
- History of injury or disease given by employee:
Resin, Fiberglass exposure
- 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: 5/5/08 (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) HEIDI M. THORESON, PA PIPESTONE MEDICAL GROUP	SIGNATURE Heidi Thoreson	DEGREE PA-C
ADDRESS 920 4TH AVE SW, PIPESTONE, MN 56164 507-825-5700 FAX 507-825-5895 DEA- MT1547833 MN LISC-10239 UPIN Q75758 NPI-1689722027	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE	TELEPHONE #
		DATE SIGNED 5/5/08

Report of Work Ability

See Instructions on Reverse Side



RW 0 1

DO NOT USE THIS SPACE

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)

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
EMPLOYEE <i>Larry Mohr</i>	Date of Birth <i>3-24-63</i>
EMPLOYER <i>Suzlon</i>	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office *5/5/08* (date)

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

1. Employee is able to work without restrictions as of *5/5/08* (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 (Type)	SIGNATURE	DEGREE
ADDRESS	<i>Heidi Thoreson</i>	<i>PA-C</i>
		STATE
CITY	AREA CODE	TELEPHONE #
		DATE SIGNED <i>5/5/08</i>



FITNESS FOR DUTY

Employees who are absent due to illness or injury (either work-related or non-occupational) may be required to have their physician or other qualified health provider complete a Fitness for Duty Certification before returning to work. The completed form should be returned to Human Resources will make a determination as to his/her ability to return to work. No employee will be allowed to return to work without a satisfactory Fitness for Duty Certification on file.

Employee Name: Larry G. Mohr Date: 5-5-08

Is employee able to perform the functions of his/her position? Yes No

Any restrictions? Yes No If yes, please describe restriction(s) and duration below:

RETURN TO WORK: With No Limitations Date: 5/5/08

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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: _____

Employee Signature: _____

Physician or Practitioner Signature: Heidi Tharson PA-C

Type of Practice: (Field of Specialization) _____

3 PART DRUGS OF ABUSE TEST REQUEST



SPECIMEN ID U8859912

Employer: SUZLON ROTOR CORPORATION
1711 S HWY 75
PIPESTONE, MN 56164



Account #

1 To be completed by COLLECTOR / DONOR

Donor I.D. 504 747431
Donor Name (last, first) or SSN Mohr Larry
Donor Daytime Phone 605 413 7078
Social Security No, Employee No. or other Identification No.
Specimen Type: Blood Urine Oral Fluid
Referring Phys. / Company

MRO:

DONOR CONSENT I certify that I provided my specimen to the collector, that the specimen container was sealed with a tamper-proof seal in my presence; and that the information provided on this form and on the label affixed to the specimen bottle is correct. I authorize MEDTOX to release the results of the tests to my employer, prospective employer, employer representative and/or their authorized healthcare professionals.

Account # 73470

Test(s) Ordered 58043

Signature Gary D. Mohr
DATE 05-05-08



2 To be Completed by COLLECTOR Indicate Reason for Test
 Pre-employment Random Reasonable Suspicion Other (specify):
 Return to Duty Follow-up Post Accident Periodic Medical

3 To be Completed by COLLECTOR Specimen temperature must be read within 4 minutes of collection
Specimen Temperature within range: (90°-100°F/32°-38°C)
 YES No, Remark Required 1st attempt QNS 2nd out of temp 3rd witnessed QNS 81605

4 To be Completed by COLLECTOR Collection Site Location: Facility and Address
PIPESTONE COUNTY MED CENTER PIPESTONE, MN 56164
Collection Site Phone No. (507) 825-5811 Fax No. (507) 825-6081

Date and Time of Collection 05-05-2008 12:50 pm
Remarks Concerning Collection: 1st attempt QNS, 2nd attempt temp out 59.8, 3rd attempt witnessed collection - donor

I, the collector, by signing below certify that the specimen identified on this form is the specimen given to me by the donor identified above and that it has been collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements. Donor attempted witness collection @ 1400 hrs

Signature of Collector Julie C. Stevens 5/5/08
(PRINT) Collector's Name (First, MI, Last)

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab
 DHL Local Courier
 Other

5



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