

Report of Work Ability

See Instructions on Reverse Side



R W 0 1

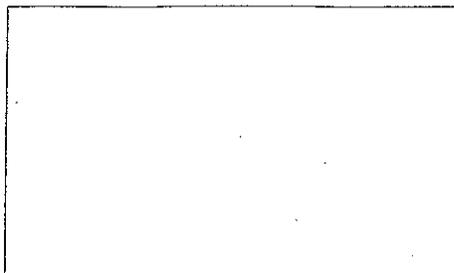
DO NOT USE THIS SPACE

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 455496173	DATE OF INJURY 4-25-08
EMPLOYEE Lee Ann Trujillo	Date of Birth 9-25-76
EMPLOYER Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	



Date of most recent examination by this office 5-15-08 (date)

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

1. Employee is able to work without restrictions as of 5/16/08 (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 or Print) BRUCE W KOCOUREK, DO	SIGNATURE <i>B. Kocourek</i>	DEGREE
ADDRESS PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744	STATE	LICENSE #/REGISTRATION #
CITY DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #
		DATE SIGNED 5/15/08

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 <i>455496173</i>	DATE OF INJURY <i>4-25-08</i>	DOB <i>9-25-76</i>
EMPLOYEE <i>LeeAnn Trujillo</i>	EMPLOYER <i>Suzlon Potter</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

1. Date of first examination for this injury by this office: *5-15-08* (date)
2. Diagnosis (include all ICD-9-CM codes):
contusion @ post ribs & fall
3. History of injury or disease given by employee:
fell on ice in parking lot @ 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: *5/15/08* (date)
9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) No Yes Date reached: (date)
10. Has the employee sustained any permanent partial disability from the injury? No Yes Too early to determine
The permanent partial disability is 5223. % of the whole body. This rating is based on Minn. Rules:

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

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