



# Medical Referral to Employer

Employee Name: Megan Fehl Date of Injury: 2-28-08

**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.

\_\_\_\_\_  
Employee Signature Date

Medical Provider \_\_\_\_\_ Date / Time of Appt: \_\_\_\_\_

**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: contact dermatitis  Non-work related  
 Undetermined

Treatment Plan: Midrol, lasynch, Zyrtec  Work related

RETURN TO WORK:  With No Limitations Date: 3/3/08  
(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: \_\_\_\_\_ 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: \_\_\_\_\_ Provider's Comments: \_\_\_\_\_

maximal skin protection  
Medical Provider Signature: B. Kraunhafer Date: 3/3/08