Referral for Medical Treatment Report to Employer

S.R.C. - Pipestone, MN U.S.A.

Employee Name: Marcie DeZeeuw **Date of Injury:** 3

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.

Marcie A DeZeeuw — Employee Signature

02.07.08 — Date

Medical Provider Kocourek **Date / Time of Appt:** 2/7/08 1540

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:

Wausau Insurance
PO Box 8016
Wausau, WI 54402

1-877-870-1542

Incomplete billings or those mailed directly to Suzlon Rotor Corporation may result in slow payment processes.

Diagnosis: lateral epicondylitis ② elbow

____ Non-work related
____ Undetermined
X Work related

Treatment Plan: NSAID, ice, forearm support band **Date:** 2/8/08

RETURN TO WORK: X **With No Limitations**
(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: 2wks **Provider's Comments:** reg duties

Medical Provider Signature: B. Kocourek **Date:** 2/7/08

Report of Work Ability

See Instructions on Reverse Side

RW01

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
504 86 7499	
EMPLOYEE: Marcie Dezeeuw	Date of Birth: 12-4-59
EMPLOYER: Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 2-7-08 (date)

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

1. [X] Employee is able to work without restrictions as of 2/8/08 (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)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONE COUNTYMEDICAL CENTER ADDRESS 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: 2/7/08

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
504 86 7499		12-4-59
EMPLOYEE: Maraie Dezeeuw	EMPLOYER: Suzlon	
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: 2-7-08 (date)
2. Diagnosis (include all ICD-9-CM codes):
   lateral epicondylitis (L) elbow
3. History of injury or disease given by employee:
   hurt elbow pulling green mesh (shelling)
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: 2/7/08 (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 (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO	B. Kocourek	
ADDRESS: PIPESTONE COUNTYMEDICAL 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: 2/7/08

MN HC01 (7/01).