

Report of Work Ability

See Instructions on Reverse Side

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)



R W 0 1

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 <i>476172936</i>	DATE OF INJURY <i>3-13-08</i>
EMPLOYEE <i>Matthew Jones</i>	Date of Birth <i>2-21-89</i>
EMPLOYER <i>Suzlon</i>	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office *3/13/08* (date)

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

1. Employee is able to work without restrictions as of *3/13/08* (date)

2. Employee is able to work with restrictions, from _____ (date) to _____ (date)

The restrictions are:

protective clothing

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 KOCQUREK, 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 HK0472477 MN LJC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #	DATE SIGNED <i>3/13/08</i>

Health Care Provider Report

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

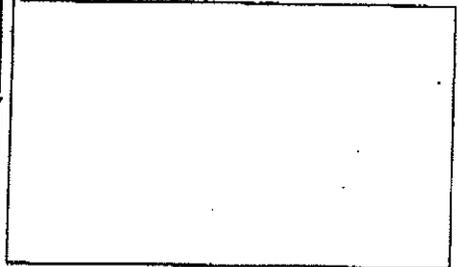


HC 01

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER <i>476172936</i>	DATE OF INJURY <i>3-13-08</i>	DOB <i>2-21-89</i>
EMPLOYEE <i>Matthew Jones</i>	EMPLOYER <i>Suzlon</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: _____ (date)
- Diagnosis (include all ICD-9-CM codes):
contact keratitis
- History of injury or disease given by employee:
rash with fiberglass exposure @ work
- 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: *3/13/08* (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) BRUCE W KOCUREK, 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	SIGNATURE <i>B. Kocurek</i>	DEGREE
ADDRESS	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE	TELEPHONE #
		DATE SIGNED <i>3/13/08</i>