Medical Referral to Employer

Employee Name: Michael Steffan **Date of Injury:** 6/26/08

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

6-26-08
Date

Medical Provider Larry D Christensen MD **Date / Time of Appt:** 6/26/08 10:35

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: low Back Pain

Treatment Plan: cold packs x 72 hours

____ **Non-work related**

____ **Undetermined**

X **Work related**

RETURN TO WORK: X **With No Limitations** **Date:** 6-27-08

(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: 2 weeks **Provider's Comments:** _____

Medical Provider Signature: [signature] **Date:** 6-26-08

Please fax back to 507.562.6800 – Attn CMG.

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: Michael Stuffan Date: 6/26/08

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

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

RETURN TO WORK: X With No Limitations Date: 6-27-08

(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: _____

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_____ 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: 2 wks Provider's Comments: _____

Employee Signature: _____

Physician or Practitioner Signature: [signature] MD

Type of Practice: (Field of Specialization) MD - family practice

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
473219712	6-26-08
EMPLOYEE: Michael Steffen	Date of Birth: 3-21-88
EMPLOYER: CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 6-26-08 (date)

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

1. [X] Employee is able to work without restrictions as of 6-27-08 (date)

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

The restrictions are:

3. [X] Employee is unable to work at all, from 6-26-08 (date) to (date)

The next scheduled visit is: [ ] as needed OR (date) 2 weeks

NAME (Type or Print)	SIGNATURE	DEGREE
ADDRESS: LARRY D CHRISTENSEN, MD PIPESTONE FAMILY CLINIC 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 EXT. 4771 FAX 507-825-4763 DEA-AC7916539 MN LISC-23799 UPIN D75623		MD
CITY	STATE	LICENSE #/REGISTRATION #
	AREA CODE / TELEPHONE #	DATE SIGNED: 6/26/08

MN RW01 (7/01)