

Report of Work Ability

See Instructions on Reverse Side



R W 0 1

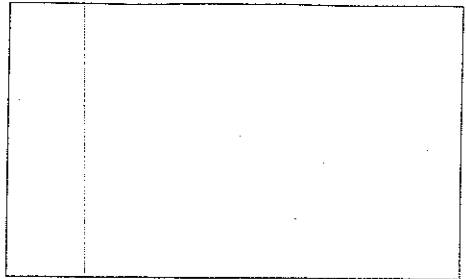
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

This form must be provided to the employee.
(Minn. Rules 5221.0410, subp. 6)

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 475-47-4615	DATE OF INJURY 4-16-08
EMPLOYEE Omar Mohamed	Date of Birth 8-16-83
EMPLOYER Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	



Date of most recent examination by this office (date)

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

1. Employee is able to work without restrictions as of (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		SIGNATURE <i>Larry D Christensen</i>		DEGREE MD	
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 LTSC-23799 UPIN D75623		STATE	LICENSE #/REGISTRATION #		
CITY	STATE	AREA CODE	TELEPHONE #	DATE SIGNED 6-18-08	

Health Care Provider Report

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



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

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER 475-47-4615	DATE OF INJURY 4-16-08	DOB 8-16-83
EMPLOYEE Omar Mohamud	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: **5 4-17-08** (date)
2. Diagnosis (include all ICD-9-CM codes):
Rash
3. History of injury or disease given by employee:
Developed Rash on arms after working with pasta Resin
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: **6-18-08** (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 **0** % of the whole body. This rating is based on Minn. Rules:

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

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