



Medical Referral to Employer

Employee Name: Omair Mohamud

Date of Injury: 4-16-08

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: 4-17-08 @ 4:20

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: allergic contact dermatitis

___ Non-work related

___ Undetermined

Treatment Plan: medrol dosepack, zyrtec

Work related

RETURN TO WORK: With No Limitations

Date: 4/18/08

(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: rec:

maximal skin protection

Medical Provider Signature: B. Pasunke Date: 4/17/08



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: Omar Mohamed Date: 4-17-08

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

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

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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: _____ Provider's Comments: _____

Employee Signature: _____

Physician or Practitioner Signature: B. Hamud

Type of Practice: (Field of Specialization) FP