



1661 St Anthony Ave
 Saint Paul, MN 55104-7633
 Phone: 651-968-5300 Fax: 651-646-0205

REPORT OF WORKABILITY

Date 10/15/2014 Appointment Time 11:00

Employee Ruth Ogud

Patient ID XXX-XX-4993 DOB 01/01/1971 DOI 09/15/2014 MCO _____

Employer Corporate Management Group

Contact person Dan Zezza Fax # _____

Diagnosis R. leg contusion

Work related Not work related Undetermined
 Permanent Disability? Likely Not likely Undetermined
 MMI? No Yes If yes, give date _____

ART _____
 TI _____
 TO _____
 Employer Contacted?
 Yes No
 Faxed Phoned

Return to work with no limitations on _____
 Return to work with limitations on 10-15-14 through 10-29-14
 Unable to work from _____ through _____

Avoid the following hand and wrist activities

	Left	Right	Both
Operate power/vibrating tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coarse manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Torquing/crimping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping-light/heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoid use of hand(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-stretched arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

No operating forklift
 No operating machinery
 No driving motor vehicle

EMPLOYEE'S RESTRICTIONS

	NOT AT ALL	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%		NOT AT ALL	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%
Lift/Carry:					Bend				
0-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____degrees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist/Turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneel/Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Stand/Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Push/Pull:					Overhead Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-25 lbs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ladder/Stair Climb	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rotate Activities/Positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-75 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
76-100 lbs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

- Lift with palms up
- Change positions as needed
- Lift from mid thigh to mid chest

COMMENTS/TREATMENT: _____

- Keep wound clean and dry. Change dressing every _____ First Aid
- Medication Tylenol @ work Over Counter Meds
- Ice Heat Elevate Splint/Brace Crutches Head injury sheet Wound care sheet given
- Physical Therapy
- Specialist Referral
- Return to Clinic on 10-29-14 Date _____ Time 11:00am

The above has been discussed with the employee.

Signature [Signature]
 John Kipp, MD Physician