

Report of Work Ability

See Instructions on Reverse Side



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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 607326144	DATE OF INJURY 5-30-08
EMPLOYEE Ramon Campos	Date of Birth 5-17-67
EMPLOYER C-MG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 6/13/08 (date)

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

1. Employee is able to work without restrictions as of _____ (date)

2. Employee is able to work with restrictions, from 6/14/08 (date) to 6/20/08 (date)

The restrictions are:

no lifting or repetitive use @ hand > 40# or no overhead work

3. Employee is unable to work at all, from _____ (date) to _____ (date)

The next scheduled visit is: as needed OR 6/20/08 (date)

NAME (Type or Print) BRUCE W KOCOUREK, 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 BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #
		DATE SIGNED <u>6/13/08</u>



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: Ramon Campos Rea Date: 6/13/08

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:

RETURN TO WORK: With No Limitations Date: _____

(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: _____

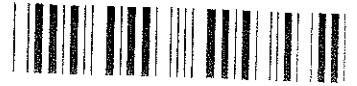
Employee Signature: [Signature]

Physician or Practitioner Signature: [Signature]

Type of Practice: (Field of Specialization) FP

Health Care Provider Report

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



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DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER <i>607 3260144</i>	DATE OF INJURY <i>5-30-08</i>	DOB <i>5-17-67</i>
EMPLOYEE <i>Ramon Campos</i>	EMPLOYER <i>CMG</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: *6-13-08* (date)
 - Diagnosis (include all ICD-9-CM codes):
strain (2) upper back + shoulder
 - History of injury or disease given by employee:
hurt (2) arm + back pulling rolls of fiberglass
 - 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: *6/13/08* (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?
The permanent partial disability is _____ % of the whole body. This rating is based on Minn. Rules:
 No Yes Too early to determine
- | | | | |
|--------------|--|--|--|
| <i>5223.</i> | | | |
| <i>5223.</i> | | | |

NAME (Type or Print) BRUCE W KOCOUREK, DO ADDRESS PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 CITY DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	SIGNATURE STATE LICENSE #/REGISTRATION # AREA CODE TELEPHONE # DEGREE DATE SIGNED <i>6/13/08</i>
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