



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

REPORT OF WORKABILITY

Date 10/29/2014 Appointment Time 11:00

Employee Ruth Ogud

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

Employer Corporate Management Group

Contact person Dan Zezza Fax # _____

Diagnosis R. foot/ankle sprain

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

Return to work with **no limitations** on 10-29-14
 Return to work with **limitations** on ___/___/___ through ___/___/___
 Unable to work from ___/___/___ through ___/___/___

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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___ degrees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11-20 lbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Twist/Turn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21-50 lbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Kneel/Squat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
51-100 lbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					Stand/Walk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Push/Pull:					Overhead Reaching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0-25 lbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ladder/Stair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26-50 lbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Climb	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
51-75 lbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rotate Activities/Positions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
76-100 lbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					

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

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

Avoid the following hand and wrist activities	Left	Right	Both
Operate power/vibrating tools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coarse manipulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Torquing/crimping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grasping-light/heavy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoid use of hand(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Out-stretched arms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> No operating forklift			
<input type="radio"/> No operating machinery			
<input type="radio"/> No driving motor vehicle			

COMMENTS/TREATMENT: _____

- Keep wound clean and dry. Change dressing every _____ First Aid
- Medication _____ Over Counter Meds
- Ice Heat Elevate _____ Splint/Brace _____ Crutches Head injury sheet Wound care sheet given
- Physical Therapy _____
- Specialist Referral _____ Date _____ Time _____
- Return to Clinic on any problems Date _____ Time _____

The above has been discussed with the employee.

Signature John Kipp, MD Physician