



Medical Referral to Employer

Employee Name: Samantha Brady

Date of Injury: 1-18-07
~~1-17-07~~

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.

Samantha Brady
Employee Signature

11-18-07 01-18-08
Date

Medical Provider PCMC

Date / Time of Appt: _____

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: contact dermatitis

___ Non-work related

___ Undetermined

Treatment Plan: prednisone, zyrtec

Work related

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: _____

Medical Provider Signature: B. Rowland Date: 1/18/08



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: Samantha Brady Date: 11-18-08

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: 1/19/09

(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: _____

Physician or Practitioner Signature: B. Rumbak

Type of Practice: (Field of Specialization) FP

Report of Work Ability

See Instructions on Reverse Side



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

RW01

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 469084132	DATE OF INJURY 1-17-08
EMPLOYEE Samantha Brady	Date of Birth 12-8-83
EMPLOYER Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office

1-18-08	(date)
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Select the appropriate option(s) below and fill in the applicable dates.

1. Employee is able to work without restrictions as of 1/18/08 (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 (Type or Print) BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER	SIGNATURE <i>B. Kocourek</i>	DEGREE
ADDRE: 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	STATE	LICENSE #/REGISTRATION #
CITY UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #
		DATE SIGNED 1/18/08

Health Care Provider Report

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

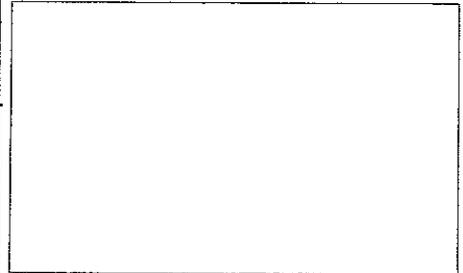


HC01

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

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER <i>469 084 132</i>	DATE OF INJURY <i>1-17-08</i>	DOB <i>12-8-83</i>
EMPLOYEE <i>Samantha Brady</i>	EMPLOYER <i>Suzlon Rotor</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

1. Date of first examination for this injury by this office: (date)
2. Diagnosis (include all ICD-9-CM codes):
contact dermatitis hands, neck, face
3. History of injury or disease given by employee:
rash to exposure to fiberglass
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: *1/18/08* (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 % of the whole body. This rating is based on Minn. Rules:

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

NAME (Type or Print) BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER ADDRESS 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 CITY UPIN D25406 NPI 1699738559	SIGNATURE <i>B. Kocourek</i> DEGREE STATE LICENSE #/REGISTRATION # AREA CODE TELEPHONE # DATE SIGNED <i>1/18/08</i>
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