

RETURN TO WORK FORM

Patient Tommy Jazura Today's Date 2-20-08
 Employer [Signature] Date of Birth 2-10-57
 Occupation _____ Date of Injury 2-1-08
 Diagnosis/Impression finger

Is This Injury Work Related? (Doctor's Opinion) Yes No Uncertain

Treatment Plan PT 1x/week

Patient can return to work: with limitations on: _____ without limitations on: 2:55-08

Patient is off work: _____ Next Appointment: 4-02

DEGREE	LIMITATIONS	LIMITATIONS CON'T.																																				
<input type="checkbox"/> Sedentary Work: Lifting up to 10 pounds occasionally and frequently lifting and/or carrying such articles as dockets, ledgers, & small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.	1. In a work day patient may: a. Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 6-8 Hours <input type="checkbox"/> 1-4 Hours <input type="checkbox"/> 8-10 Hours <input type="checkbox"/> 4-6 Hours <input type="checkbox"/> 10+ Hours b. Sit <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours <input type="checkbox"/> 8-10 Hours <input type="checkbox"/> 10+ Hours c. Drive <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours <input type="checkbox"/> 8-10 Hours <input type="checkbox"/> 10+ Hours	5. Other: _____ 																																				
<input type="checkbox"/> Light Work: Lifting up to 20 pounds occasionally with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.	2. Patient may use injured hand for: <table border="0"> <tr> <td></td> <td>Never</td> <td>Rare</td> <td>Occ.</td> <td>Freq.</td> <td>Cont.</td> </tr> <tr> <td><input type="checkbox"/> Simple Grasping</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Fine Manipulation</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Pushing/Pulling</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Firm Grasping</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Patient is not to use injured hand.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Never	Rare	Occ.	Freq.	Cont.	<input type="checkbox"/> Simple Grasping	<input type="checkbox"/> Fine Manipulation	<input type="checkbox"/> Pushing/Pulling	<input type="checkbox"/> Firm Grasping	<input type="checkbox"/> Patient is not to use injured hand.						DEFINITIONS In an 8 hour period: Rarely = 0-10% of time (=45 min.) Less than 6 reps per hour Occasionally = 11-33% (=50-100 min.) 7-19 reps per hour Frequently = 34-67% (=150-300 min.) 20-40 reps per hour Continuously - 68-100% (=300-450 min.) 40+ reps per hour																				
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<input type="checkbox"/> Patient is not to use injured hand.																																						
<input type="checkbox"/> Medium Work: Lifting up to 50 pounds occasionally with frequent lifting and/or carrying of objects weighing up to 25 pounds	3. Patient is able to <input type="checkbox"/> Bend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Squat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Climb Stairs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Reach Above Shoulder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kneel <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CONDITION <input type="checkbox"/> Worse <input type="checkbox"/> Discharged <input type="checkbox"/> Improved <input type="checkbox"/> Resolved																																				
<input type="checkbox"/> Heavy Work: Lifting up to 100 pounds occasionally, with frequent lifting and/or carrying of objects weighing up to 50 pounds.	4. Patient may use feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No	No change in: _____ Diagnosis _____ Treatment _____ Work _____ Restriction																																				
<input type="checkbox"/> Very Heavy Work: Lifting objects in excess of 100 pounds occasionally with frequent lifting and/or carrying of objects weighing 50 pounds or more; exerting 20 lbs of force constantly.																																						
<input type="checkbox"/> Work compatible with splints, braces, casts, bandages, crutches.																																						

Comments: _____

Signature: [Signature] Date: 2-20-08
 Provider: _____ Phone: 331-5890 or 888-331-5890
 (Please Print Name)

Avera McKennan Hospital

Sioux Falls, SD 57117-5045



JAQUA, TOMMY L

IN 02/10/57 50 M 2.234

02/01/08 Looby, Peter A MD

MK0001385059 MR#: MK00364826



Discharge Date: 02/02/08

Diagnosis: 2/1 IRRIGATION & DEBRIDEMENT WITH REPAIR LEFT HAND LACERATION

Diagnosis: of laceration

Allergies: NKA

Diet: REGULAR

Activity

: UP AS TOLERATED

Special Instructions and Treatments

: KEEP DRESSING CLEAN, DRY & INTACT UNTIL RETURN APPOINTMENT WITH DR LOOBY

: NO WORK UNTIL RETURN APPOINTMENT

: ELEVATE LEFT ARM AS MUCH AS POSSIBLE

: CALL YOUR PHYSICIAN IF TEMP >101 OR IF PAIN NOT RELIEVED BY PRESCRIBED

: PAIN MEDICATION.

: CALL YOUR PHYSICIAN WITH ANY OTHER CONCERNS

Contact Dr for More Information

: DR. LOOBY AT 1-888-331-5890 OR 331-5890

Follow up Appointments and Exams

: *MAKE RETURN APPOINTMENT WITH DR. LOOBY ON THURSDAY*

Med Reconciliation completed and verified: Y

If you have questions regarding your medications, please contact your physician.

Medication, Dose, When to take it, Why you take it

1. Keflex (Cephalexin Monohydrate) 250 MG

Oral Three times a day

>*ANTIBIOTIC. TAKE THREE TIMES

>A DAY FOR 3 DAYS. LAST DOSE;

>NONE GIVEN AT HOSPITAL

2. Norco 5/325MG (Hydrocodone/Acetaminphen) 1 - 2 EACH

Oral Every 4 hours As Needed

>TAKE 1-2 TABLETS EVERY 4-6

>HOURS AS NEEDED FOR PAIN. *DO

>NOT EXCEED 4000 MG OF TYLENOL

>IN 24 HOURS* LAST DOSE: 2/2/08 1115

Pneumonia vaccine: CritNotMet-<65 no illness

PneuV Date:

Flu Vaccine this year: Patient refused

FluV Date:

Returned to patient:

Belongings Returned

Smokes Now: Yes

Education Materials Provided:

Nursing Discharge Summary (permanent part of the Medical Record)

(Signed copy to Medical Records and copy to Patient)

Run on 02/02/08 at 1337

(Continued...)

Avera McKennan Hospital

Sioux Falls, SD 57117-5045



JAQUA, TOMMY L
IN 02/10/57 51 M 2.252
02/11/08 Carlson, Walter O MD
MK0001388257 MR#: MK00364826



Discharge Date: 02/13/08

Diagnosis: 2/11 cellulitis left hand
Allergies: NKA
Diet: Regular

Activity

: As tolerated

Special Instructions and Treatments

: wash left hand wound daily with peroxide and then dry. change dressing as
: needed.
: Call if you have any questions or concerns or if infection gets worse.
: unrelieved pain in the left hand, increased temperature of 100.5,
: increased drainage.

Contact Dr for More Information

: Call Dr. Carlson's office if you have any questions 1-888-331-5890 or
: 605-331-5890

Follow up Appointments and Exams

: DR. Carlson on Wednesday 2/20/08 at 10:00am

Med Reconciliation completed and verified: Y

If you have questions regarding your medications, please contact your physician.

Medication, Dose, When to take it, Why you take it

1. Hydrogen Peroxide 3% Soln (Hydrogen Peroxide)

>WASH LEFT HAND WOUND DAILY
>WITH PEROXIDE AND THEN DRY.
>CHECK INCISION,
>REINFORCE/CHANGE DRESSING PRN
>X 5 DAYS. LAST DOSE: 2/13/08

2. Norco 5/325MG (Hydrocodone/Acetaminphen) 1 - 2 TAB

Oral As Needed

>LAST DOSE: 2/13/08

LAST DOSE 2:45 pm

3. Augmentin (Amoxicillin/Clavulanate K) 875 TAB

Oral Twice a day

>AUGUMENTIN 875/125

>ANTIBIOTIC LAST DOSE: NONE

>GIVEN

4. Levaquin (Levofloxacin) 1 TAB

Oral Daily

>ANTIBIOTIC LAST DOSE: NONE

>GIVEN

Pneumonia vaccine: CritNotMet-<65 no illness
Flu Vaccine this year: Patient refused

PneuV Date:
FluV Date:

Returned to patient:

Nursing Discharge Summary (permanent part of the Medical Record)
(Signed copy to Medical Records and copy to Patient)
Run on 02/13/08 at 1437 (Continued...)



Medical Referral to Employer

Employee Name: Tom Jagua Date of Injury: 2-1-08

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.

Tom Jagua Employee Signature Date 2-7-08

Medical Provider _____ Date / Time of Appt: 2-7-08 - 7:00

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: _____ Non-work related

_____ Undetermined

Treatment Plan: _____ 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: 2-11-08 Provider's Comments: off work until seen by P.A. 2-11-08

Medical Provider Signature: [Signature] Date: 2-7-08

Please fax back to 507.562.6800 - Attn CMG.



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: Tom Jagua Date: 2-7-08

Is employee able to perform the functions of his/her position? Yes No *off work until 2-11-08 when seen by PA.*
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.)

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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: Tom Jagua

Physician or Practitioner Signature: _____

Type of Practice: (Field of Specialization) _____