

ESSG Medical Referral to Employer

Employee Name: Tyler Schons

Date of Injury: 4-22-08

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.

Employee Signature _____

Date _____

Medical Provider H. Thorsen

Date / Time of Appt: 4-22-08 / 11:30

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:

ESSG
7300 Metro Blvd
Ste. 635
Edina, MN 55439
(952)835-1288
Fx: (952)835-1255

Diagnosis: Allergic Dermatitis

Non-work related

Undetermined

Treatment Plan: medications

Work related

RETURN TO WORK: With No Limitations

Date: 4-22-08

(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: _____

keep arms covered

Medical Provider Signature: Heidi Thorsen PAC

Date: 4-22-08



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: Tyler Schon Date: 4-22-08

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: _____

Please keep arms & hands covered at all times

Employee Signature: [Signature]

Physician or Practitioner Signature: Heidi Thoresen PA-C

Type of Practice: (Field of Specialization) _____

Health Care Provider Report

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



H C 0 1

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER 471-21-7506	DATE OF INJURY 4-22-08	DOB 3-26-90
EMPLOYEE Tyler Schon	EMPLOYER Suzlon	
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: 4-22-08 (date)
- Diagnosis (include all ICD-9-CM codes):
Allergic Dermatitis
- History of injury or disease given by employee:
Reaction to chemicals at work
- 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: 4-22-08 (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? 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 (T)	SIGNATURE Heidi Thoreson		DEGREE PA-C
ADDRESS HEIDI M. THORESON, PA PIPESTONE MEDICAL GROUP 920 4TH AVE SW, PIPESTONE, MN 56164 507-825-5700 FAX 507-825-5895 DEA- MT1547833 MN LISC-10239 UPIN Q75758 NPI - 1689722027	STATE	LICENSE #/REGISTRATION #	
CITY	AREA CODE	TELEPHONE #	DATE SIGNED 4-22-08

Report of Work Ability

See Instructions on Reverse Side



RW01

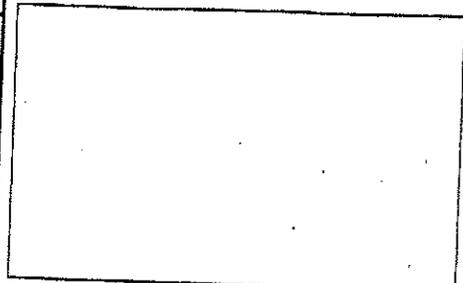
DO NOT USE THIS SPACE

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	DATE OF INJURY 4-22-08
EMPLOYEE Tyler Schons	Date of Birth 3-26-90
EMPLOYER Surdon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	



Date of most recent examination by this office. 4-22-08 (date)

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

1. Employee is able to work without restrictions as of 4-22-08 (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) HEIDI M. THORESON, PA PIPESTONE FAMILY CLINIC 920 4TH AVE SW, PIPESTONE, MN 56164 507-825-5700 FAX 507-825-5895 DEA- MT1547833 MN LTSC-10239 UPIN Q75758 NPI - 1689722027	ADDRESS	CITY	SIGNATURE Heidi Thoreson	DEGREE PA-C
			STATE	LICENSE #/REGISTRATION #
			AREA CODE	TELEPHONE #
			DATE SIGNED 4-22-08	