

# Report of Work Ability

See Instructions on Reverse Side



R W 0 1

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)

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 279089809	DATE OF INJURY
EMPLOYEE Vacaba Kone	Date of Birth 10-10-64
EMPLOYER CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 6-3-08 (date)

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

1.  Employee is able to work without restrictions as of 6/3/08 (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 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 6/3/08

# Health Care Provider Report

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

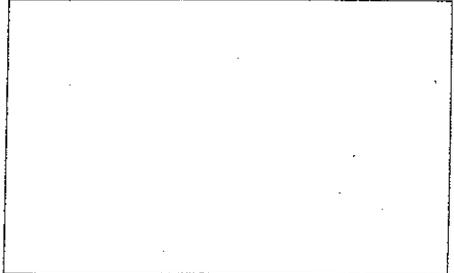


HC 01

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

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER <i>279089809</i>	DATE OF INJURY	DOB <i>10-10-64</i>
EMPLOYEE <i>Vadaba Kone</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

1. Date of first examination for this injury by this office: *6-3-08* (date)
2. Diagnosis (include all ICD-9-CM codes):  
*irritation (e) tympanic membrane*
3. History of injury or disease given by employee:  
*air hose blown into (e) ear*
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: *6/3/08* (date)
9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back)  No  Yes Date reached: (date)
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	SIGNATURE <i>B. Kourek</i>	DEGREE
ADDRESS PIPESTONE COUNTY MEDICAL CENTER 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 <i>6/3/08</i>



# 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: Vacaba Kone Date: 6/2/08

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: 6/3/08

(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: \_\_\_\_\_

Employee Signature: [Signature]

Physician or Practitioner Signature: B. Rowland

Type of Practice: (Field of Specialization) FP

3 PART DRUGS OF ABUSE TEST REQUEST



SPECIMEN ID **U8860058**

Employer:  
SUZLON ROTOR CORPORATION  
1711 S HWY 75  
PIPESTONE, MN 56164



Account #

**1 To be completed by COLLECTOR / DONOR**

Social Security No, Employee No. or other Identification No.  Blood  Urine  Oral Fluid

Donor I.D. **279089809**

Donor Name (last, first) or SSN **KONE VALLAIA**

Donor Daytime Phone **6053716333** Referring Phys. / Company **SUZLON ROTOR**

**DONOR CONSENT** I certify that I provided my specimen to the collector, that the specimen container was sealed with a tamper-proof seal in my presence, and that the information provided on this form and on the label affixed to the specimen bottle is correct. I authorize MEDTOX to release the results of the tests to my employer, prospective employer, employer representative and/or their authorized healthcare professionals.

Signature: *[Handwritten Signature]* DATE: **06032008**

MRO:

Account # **93470**

Test(s) Ordered  **95000**



**2 To be Completed by COLLECTOR** Indicate Reason for Test:  Pre-employment  Random  Reasonable Suspicion  Other (specify):  Return to Duty  Follow-up  Post Accident  Periodic Medical

**3 To be Completed by COLLECTOR** Specimen temperature must be read within 4 minutes of collection. Specimen Temperature within range: (90°-100°F/32°-38°C)  YES  No, Remark Required **81605**

**4 To be Completed by COLLECTOR** Collection Site Location: Facility and Address **481 PIPESTONE COUNTY MED CENTER PIPESTONE, MN 56154**

Collection Site Phone No. **(507) 825-5811** Fax No. **(507) 825-6081**

Date and Time of Collection: **06032008 1116**  am  pm

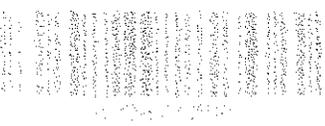
Remarks Concerning Collection: **None**

I, the collector, by signing below certify that the specimen identified on this form is the specimen given to me by the donor identified above and that it has been collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

x *[Handwritten Signature]*  
Signature of Collector  
**Michelle VanderWal**  
(PRINT) Collector's Name (First, MI, Last)

**SPECIMEN BOTTLE(S) RELEASED TO:**  
Name of Delivery Service Transferring Specimen to Lab  
 DHL  Local Courier  
 Other \_\_\_\_\_

**5**



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