

		Referral for Medical Treatment Report to Employer
S.R.C. - Pipestone, MN U.S.A.		

Employee Name: Will Clipp Date of Injury: 4-14-2008

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 _____ 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:

Wausau Insurance
PO Box 8016
Wausau, WI 54402
1-877-870-1542

TFE
CMA employee
communicated to Ashly@CMA
Levi@PipestoneMedical

Incomplete billings or those mailed directly to Suzlon Rotor Corporation may result in slow payment processes.

Diagnosis: upper back, neck & head strain & spasm _____ Non-work related
 _____ Undetermined
 Treatment Plan: NSAID, muscle relaxant, PT _____ Work related

RETURN TO WORK: _____ With No Limitations Date: 4/16/08
 (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: 5 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: no overhead work

Medical Provider Signature: B. Braunschweig Date: 4/16/08

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 460 85-6872	DATE OF INJURY 4-14-08
EMPLOYEE William Clipp	Date of Birth 44-79
EMPLOYER Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office (date)

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

1. Employee is able to work without restrictions as of (date)

2. Employee is able to work with restrictions, from (date) to (date)

The restrictions are:

no lifting > 10#
no overhead work

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	SIGNATURE <i>B Kocourek</i>	DEGREE
ADDRESS PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744	STATE	LICENSE #/REGISTRATION #
CITY DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #
		DATE SIGNED 4/16/08

Health Care Provider Report

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

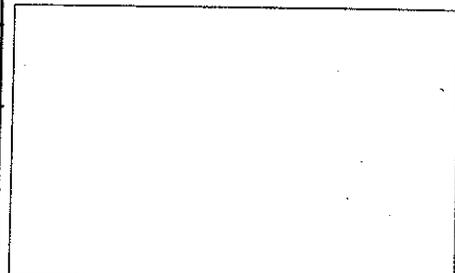


HC01

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

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER 460 85 6872	DATE OF INJURY 4-14-08	DOB 4-4-79
EMPLOYEE William Clip	EMPLOYER Suzlon Rotor	
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: (date)
- Diagnosis (include all ICD-9-CM codes):
- History of injury or disease given by employee:
- 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: (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 (Type or Print) BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	SIGNATURE <i>B. Kocourek</i>	DEGREE
CITY UPIN D25406 NPI 1699738559	STATE	LICENSE #/REGISTRATION #
	AREA CODE	TELEPHONE #
		DATE SIGNED 4/16/08