



S.R.C. - Pipestone, MN U.S.A.

Referral for Medical Treatment Report to Employer

Employee Name: Tia Preston Date of Injury: 11-28-07

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.

Tia Preston Employee Signature Date 11-28-07

Medical Provider LD Christensen Date / Time of Appt: 11-28-07 4:00pm

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

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

Diagnosis: Dorsalgia Non-work related

Undetermined

Treatment Plan: Meds 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: 1 week Provider's Comments: _____

Medical Provider Signature: LD Christensen MD Date: 11-28-07

Report of Work Ability

See Instructions on Reverse Side



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

R W O 1

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 <i>396967642</i>	DATE OF INJURY
EMPLOYEE <i>Tia M. Preston</i>	Date of Birth <i>11-4-80</i>
EMPLOYER <i>Suzlon</i>	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office *11-28-07* (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:

3. Employee is unable to work at all, from *11-28-07* (date) to (date)

The next scheduled visit is: as needed OR (date) *1 week*

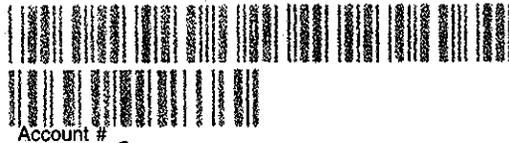
NAME (Type or Print) LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP ADDR 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 FAX 507-825-4744 DEA-AC7916539 MN LISC-23799 UPIN D75623	SIGNATURE <i>Larry D Christensen</i>	DEGREE <i>MD</i>
CITY	STATE	LICENSE #/REGISTRATION #
E	AREA CODE	TELEPHONE #
		DATE SIGNED <i>11-28-07</i>

3 PART DRUGS OF ABUSE TEST REQUEST



SPECIMEN ID **V8521886**

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



MRO:

Account # 93470

Test(s)
Ordered

88543
7 PANEL

STEP 1 To be completed by
COLLECTOR / DONOR

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

Donor I.D. **396967642**

Donor Name (last, first) or SSN **Arleston Tia**

Donor Daytime Phone **507 2745273** Referring Phys. / Company

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 *Tia Arleston* Month **11** Day **28** DATE Year **2007**

STEP 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

STEP 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) **81605**

YES No, Remark Required

STEP 4 To be Completed by **COLLECTOR**

Collection Site Location: Facility and Address **PIPESTONE COUNTY MED CENTER PIPESTONE, MN 56164**

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

Date and Time of Collection Month **11** Day **28** Year **2007** Hour **16** Minutes **20** am pm

Remarks Concerning Collection

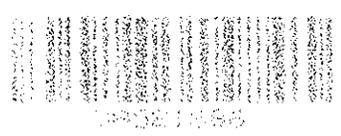
I, the collector, by signing below certify that the specimen identified on this form is the specimen given to me by the donor identified above and that it has been collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

Cindy Cunningham
Signature of Collector
Cindy Cunningham
(PRINT) Collector's Name (First, MI, Last)

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

STEP 5

Copyright Medtox 1999



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Report of Work Ability

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RW01

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SOCIAL SECURITY NUMBER 396967642	DATE OF INJURY 11-28-07
EMPLOYEE Tia M. Preston	Date of Birth 11-4-80
EMPLOYER CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office **12-5-07** (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:

3. Employee is unable to work at all, from **12-5-07** (date) to _____ (date)

The next scheduled visit is: as needed OR _____ (date) **1 week**

NAME (Type or Print)	SIGNATURE <i>Larry D Christensen</i>		DEGREE MD
ADDRESS LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 FAX 507-825-4744 DEA-AC7916539 MN LISC-23799 UPIN D75623	STATE	LICENSE #/REGISTRATION #	
CITY	AREA CODE	TELEPHONE #	DATE SIGNED 12-5-07