Fill in this information to identify the case:

Debtor 1 Belvidere Associates LLC

Debtor 2 (Spouse, if filing) _____

United States Bankruptcy Court for the: Northern District of Illinois

Case number 18-30043

Official Form 410

Proof of Claim AMENDED

04/16

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**

   Cynthia Levandoski
   Name of the current creditor (the person or entity to be paid for this claim)

   Other names the creditor used with the debtor _____

2. **Has this claim been acquired from someone else?**

   ☑ No
   ☐ Yes. From whom? _____

3. **Where should notices and payments to the creditor be sent?**
   Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent?** (if different)
Cynthia Levandoski c/o Fonfrias Law Name	_____ Name
125 S Wacker Dr. #300 Number Street	_____ Number Street
Chicago IL 60606 City State ZIP Code	_____ City State ZIP Code
Contact phone 312-969-0730	Contact phone _____
Contact email rfonfrias2025@gmail.com	Contact email _____

Uniform claim identifier for electronic payments in chapter 13 (if you use one):

_ _

4. **Does this claim amend one already filed?**

   ☑ No
   ☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**

   ☑ No
   ☐ Yes. Who made the earlier filing? _____

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
☑ No
☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ____ ____ ____ ____

7. **How much is the claim?** $ 75,000.00 . **Does this amount include interest or other charges?**
☐ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**
Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.
Work Injury as employee of Debtor

9. **Is all or part of the claim secured?**
☑ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim.*
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection: _____
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: $_____
Amount of the claim that is secured: $_____
Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amounts should match the amount in line 7.)
Amount necessary to cure any default as of the date of the petition: $_____
Annual Interest Rate (when case was filed)_____%
☐ Fixed
☐ Variable

10. **Is this claim based on a lease?**
☑ No
☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**
☑ No
☐ Yes. Identify the property: _____

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check one:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐ Up to $2,850* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$_____
☐ Wages, salaries, or commissions (up to $12,850*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$_____
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$_____
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$_____
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$_____

* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☐ I am the creditor.
☑ I am the creditor's attorney or authorized agent.
☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 01/24/2019
MM / DD / YYYY

Signature

Print the name of the person who is completing and signing this claim:

Name: Heath S. Isaacs
First name Middle name Last name

Title: Paralegal

Company: Fonfrias Law Group
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 125 S Wacker Dr., #300
Number Street

Chicago IL 60606
City State ZIP Code

Contact phone: 801-726-7704 Email: heath@casedriver.com

ILLINOIS WORKERS' COMPENSATION COMMISSION

APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

ATTENTION. Please type or print. Answer all questions. File three copies of this form.

Workers' Compensation Act X Occupational Diseases Act ___ Fatal case? No X Yes ___ Date of death ___

OCT 19 2017

Cynthia Levandoski
Employee/Petitioner

Case # 17WC030779
(Office use only)

v.

Home Owners Bargain Outlet
Belvidere Associates, LLC
Employer/Respondent

Location of accident or last exposure: Waukegan, IL (City, State)

Cynthia Levandoski	2206 Waverly Place	Waukegan	IL	60084
Injured employee's name [1]	Street address	City, State, Zip code		
Home Owners Bargain Outlet	2650 Belvidere Road	Waukegan	IL	60085
Belvidere Associates, LLC	2650 Belvidere Road	Waukegan	IL	60085
Employer's name	Street address	City, State, Zip code		

Employee information: State Employee? Yes ___ No X Male ___ Female X Married ___ Single X

Dependents under age 18 0 Birthdate 05/03/1963 Average weekly wage $ 630.00

Date of accident [2] 05/22/2017 The employer was notified of the accident orally X in writing ___

How did the accident occur? Pulling out a bedding set.

What part of the body was affected? Left hand/wrist.

What is the nature of the injury? To be determined. Return-to-work date [3] ___

Is a *Petition for an Immediate Hearing* attached? Yes ___ No X

Is the injured employee currently receiving temporary total disability benefits? Yes ___ No X

If a prior application was ever filed for this employee, list the case number and its status ___

ILL WORKERS' COMP COMM
2017 OCT 17 AM 8:30

ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's *Handbook on Workers' Compensation and Occupational Diseases* [4] for more information.

Cynthia Levandoski
Signature of petitioner

8/28/17
Date

APPEARANCE OF PETITIONER'S ATTORNEY

Please attach a copy of the *Attorney Representation Agreement.*

Signature of attorney

3416 W. Elm Street
Street address

Mark J. Vogg 1919
Attorney's name and IC code #[5] (please print)

McHenry IL 60050
City, State, Zip code

Law Offices of Thomas J. Popovich
Firm name

815-344-3797
Telephone number

E-mail address

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.
If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, Mark J. Vogg, affirm that I delivered ____ mailed with proper postage X

in the city of McHenry, IL a copy of this form

at 5:00 ~~AM~~/PM on 10-10-17 to the respondent listed on this application and to each additional party, if any, at the address listed below.

Signature of person completing *Proof of Service*

Signed and sworn to before me on _____

Notary Public

[1] In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee. Please complete information related to age, etc., for the injured employee.

[2] This may be the date of the accident, last exposure, disability, or death.

[3] If the employee has not returned to work, leave this space blank.

[4] The Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any of the Commission offices listed on the other side of this form.

[5] The Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

VISTA HEALTH SYSTEM

Corporate Health Services

WORK STATUS REPORT

EMPLOYEE NAME: Cynthia Levandoski

EMPLOYER: [illegible] Date: 5/10/17 Admit Time: 1:30

WORK STATUS

- ☐ Regular Work as of: _____
- ☐ Off Work Rest of Today Only
- ☐ Off Work Until: _____
- ☐ Work Status to be determined by Specialist
- ☐ Can Work with the Restrictions Specified Below:

LIFTING/BENDING

- ☐ No lifting, pushing or pulling over _____ lbs
- ☐ No repetitive lifting
- ☐ No lifting above the shoulder level
- ☐ Gradually increase lifting to _____ lbs over the next _____ days
- ☐ Limit bending, stooping and twisting

ARMS/SHOULDERS

- ☐ No work using RIGHT/LEFT arm
- ☐ Limited use of RIGHT/LEFT arm
- ☐ No reaching while lifting
- ☐ No working with RIGHT/LEFT arm above chest level
- ☐ Wear sling for _____ days

WALK/SIT/STAND

- ☐ Sitting job, minimum of walking
- ☐ Uses crutches
- ☐ Get up from sitting position every half hour
- ☐ Alternate standing/sitting positions every
  - ☐ half hour ☐ as needed

HANDS/WRISTS

- ☐ No use of RIGHT/LEFT hand
- ☐ Limit use of RIGHT/LEFT hand
- ☐ No tight gripping with RIGHT/LEFT hand
- ☐ No repeat twisting/bending of RIGHT/LEFT wrist
- ☐ Wear splint on RIGHT/LEFT WRIST/FINGER

SQUAT/CLIMB

- ☐ No squatting or kneeling
- ☐ No climbing
- ☐ Ground level work only

NECK

- ☐ Avoid repeated neck motions

SKIN

- ☐ Keep wound clean and dry
- ☐ Keep covered at work
- ☐ Avoid exposure to:

MACHINE/VEHICLE

- ☐ No hazardous or fast moving machinery
- ☐ No driving

PATIENT INSTRUCTIONS

- ☐ Start PT/OT
- ☒ Ibuprofen: 600 mg; every 6 hrs; take with food
- ☐ Cyclobenzaprine: _____ mg; every _____ hrs; take at bedtime ONLY; DO NOT drive within 8 hrs of each dose – may make drowsy
- ☐ Exercises/stretches as instructed
- ☐ Bacitracin to wound twice daily

ADDITIONAL INSTRUCTIONS

DIAGNOSIS: Left distal radius fracture

MD/PA Signature: [signature]

Next Appointment:	Date: _____ Time: _____ ☐ DISCHARGED
Physical/Occupational Therapy	Date: _____ Time: _____
Referral to Specialist	Doctor: [illegible] Date: _____ Time: _____ Location: [illegible] Phone: _____
Drug Screen	☐ YES ☐ NO ☐ N/A ☐ After care instructions given and discussed Discharge Time: _____

Call Corporate Health at 847.360.2860 or 847.356.4746

Vista West 2615Washington St., Waukegan Vista Lindenhurst 1050 Red Oak Lane, Lindenhurst

SIGNATURES – PATIENT [signature] RN/TECH [signature]

WHITE – CHS YELLOW – COMPANY PINK – PATIENT

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Workers' Compensation Work Status Report

Date: 5/24/2017 **Physician:** S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia **Diagnosis:** Left distal radius fracture

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 5-29-17 **with the restrictions** identified below which are expected to last through **5-30-17**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☒ Employee is **unable to return to work** as of 5-24-17 and is expected to be off of work through:
☒ 5-28-17 (date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☒ No lifting/carrying	☐ R	☒ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions
- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 5-30-17 Time: 7:40am at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Krystal Perez

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Workers' Compensation Work Status Report

Date: 5/30/2017

Physician: Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: left distal radius fracture

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

☐ Employee can return to work as of ______ **without restrictions.**

☒ Employee can return to work as of 5-30-17 **with the restrictions** identified below which are expected to last through **pending surgery**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of ______ and is expected to be off of work through:
☐ ______ (date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☒ No lifting/carrying	☐ R	☒ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

☒ Wear splint/brace/sling/cast at work
☐ Sitting only
☐ Must use crutches
☐ Walking/Standing as tolerated
☐ No driving
☐ No operating heavy equipment/moving machine
☐ No overhead work

Other Restrictions (if any): Patient may not work at the register.

Expected Follow-up Services Include:

☒ Next Appointment Date: pending surgery Time: ______ at Select Office

☐ Diagnostic Studies Requested: ______

☒ Surgery Recommended: left distal radius open reduction and internal fixation; PENDING APPROVAL

☐ Rehab (PT/OT) Recommended: ______ x per week for ______ weeks starting ______

☐ Referral to: ______

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Krystal Perez

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Hawthorn Surgery Center

Patient Centered. Extraordinary Care.

To the Patient or Guardian:

Your physician may dispense an orthopedic soft good or bracing device as part of your treatment at Hawthorn Surgical Center. These products include but are not limited to:

X Arm Sling	_____ Shoulder Abduction Sling
_____ CAM Walker Boot	_____ Crutches
_____ Knee Immobilizer	_____ Post-Op Shoe/APB
_____ TED Compression Hose	_____ 4-Prong Walker

These products are very common conservative orthopedic devices covered by most insurance companies and Medicare. The charges for a soft good or bracing device will be billed directly to your insurance company by Specialty Medical Services, INC. not Hawthorn Surgical Center. Payment for the soft good or bracing device will be made according to your members plan benefits. For example, you may be charged a deductible for the soft good or bracing device from Specialty Medical Services, INC.

If you have any questions regarding you bill or insurance claim, please contact you insurance carrier directly or Specialty Medical Services, Inc., at the number below. There is no financial interest or other business association between Specialty Medical Services, Inc. and Hawthorn Surgery Center.

Please read the assignment of insurance benefits for the soft good or bracing device that you may receive from you physician, then sign below.

Specialty Medical Services, Inc. has instituted privacy practice that are in compliance with the Health Insurance Portability and Accountability Act.

The rules in our office are intended to safeguard you private health information. We disclose only that information necessary to process your claim for benefits and payment. This include: demographic information, the nature of treatment requiring our product and pertinent information necessary to process your claim with your insurance carrier/responsible party for payment. As it is a business associate, Specialty Medical Services, Inc. complies with the HIPAA guidelines presented to you at the facility prescribing your orthotic, soft good or durable medical equipment.

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION, RELEASE OF MEDICAL INFORMATION, AND BENEFIT ASSIGNMENT DISCLOSURE FORM

SPECIALTY MEDICAL SERVICES, INC. is the supplier of the soft good, orthotic or bracing device prescribed by my physician at this facility. I authorize the release of my medical information necessary to process the resulting claim for the product(s) provided to me. Additionally, I authorize assignment of my insurance benefit to Specialty Medical Service, Inc. **I understand that I will be responsible for any co-payment, deductible or non-covered expenses that may result from this billing.**

Patient/ Guardian Signature: X [signature] Date: 6.8.17

Physician Signature: V.O. per Dr. DeLeon Date: 6.8.17

SPECIALTY MEDICAL SERVICES, INC

479 Business Center Dr.

Mount Prospect, IL 60056

(847) 720-4310 – Billing Department

Specialty Medical keep the original- one copy to patient, one copy remains in patient's chart

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Workers' Compensation Work Status Report

Date: 6/19/2017 **Physician:** S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia **Diagnosis:** Status Post Left ORIF of 3-Part Intra-Articular

Employer: Home Owner's Bargain Outlet Distal Radius Fracture

Date of Injury: 5/22/17 DOS: 6/8/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 6/26/17 **with the restrictions** identified below which are expected to last through **NEXT APPT**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☒ Employee is **unable to return to work** as of 6/19/17 and is expected to be off of work through:
☒ 6/25/17 (date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☒ No lifting/carrying	☐ R	☒ L
☒ No pushing/pulling	☐ R	☒ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): No use of arm sling

Expected Follow-up Services Include:

☒ Next Appointment Date: 7/17/17 Time: 12:15PM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☒ Rehab (PT/OT) Recommended: 2 x per week for 4 weeks starting pending WC approval

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Ofelia Diaz, CCMA

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Workers' Compensation Work Status Report

Date: 7/17/2017

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left three-part intraarticular distal radius Fracture S/P Open Reduction Internal Fixation

Employer: Home Owner's Bargain Outlet

Date of Injury: 5/22/17 DOS: 6/8/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 7/17/17 **with the restrictions** identified below which are expected to last through **8/15/17**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____ (date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☒ Not to exceed 5 lbs	☐ R	☒ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions
- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 8/15/17 Time: 8:15AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Clairie Chicas, CCMA

RF43

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BONE & JOINT
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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
07/17/2017	12:15 pm	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

Create Date: 6/19/2017 Due Date: 7/19/2017
Procedure: OT Facility: IBJI Rehab Gurnee
Ordering Provider: Serafin DeLeon - NPI # 1326091414

ILLINOIS BONE AND JOINT INSTITUTE, LLC
OCCUPATIONAL THERAPY ORDER

☐ Right ☒ Left

Patient Name: Levandoski, Cynthia Patient ID: 1520501 Diagnosis:

Treatment Frequency: ☐ x1 ☒ x2 ☐ x3 per week Treatment Duration: ☐ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☒ weeks ☐ months

☐ Right ☒ Left

SPLINT FABRICATION

Notes:

☐ Hand based
☐ Forearm based
☐ Dorsal
☐ Volar
☐ Static
☐ Dynamic
☐ Ext/Flex
☐ Pro/Sup

☐ Fingertip Protector ☐ T ☐ I ☐ L ☐ R ☐ S
☐ Mallet Finger Splint ☐ T ☐ I ☐ L ☐ R ☐ S
☐ Ulnar Gutter Splint ☐ T ☐ I ☐ L ☐ R ☐ S
☐ Radial Gutter: include ☐ T ☐ I ☐ L ☐ R ☐ S
☐ Dorsal Blocking: include ☐ T ☐ I ☐ L ☐ R ☐ S
☐ Short Opponens Splint ☐ include IP joint
☐ Long Opponens Splint ☐ Exclude IP joint
☐ Wrist Splint
☐ Elbow (arm to wrist) ☐ Other: ______

☐ DIPs ☐ flex ☐ ext
☐ PIPs ☐ flex ☐ ext
☐ MCPs ☐ flex ☐ ext
☐ Wrist ☐ flex ☐ ext
☐ Forearm ☐ pro ☐ sup
☐ Elbow ☐ flex ☐ sup

☐ Right ☒ Left

THERAPY

☐ Elbow ☒ Wrist ☐ MCPs ☐ PIPs ☐ DIPs ☐ Thumb ☐ Index ☐ Long ☐ Ring ☐ Small

☐ **Range of Motion**
☐ Unlimited Mobilization
☐ Specific Goals
☐ Active
☐ Passive
☐ Flexion
☐ Extension
☐ Pronation
☐ Supination
☐ Internal / External Rotation
☐ Abduction / Forward Flexion

☒ **Evaluate and Treat**

☐ **Soft Tissue Care**
☐ Cryotherapy
☐ Desensitization
☐ Edema Control
☐ Electrical Stim
☐ Fluidotherapy
☐ Friction Massage
☐ Iontophoresis
☐ Scar Massage
☐ TENS
☐ Ultrasound
☐ Wound Care

☐ **Strengthening**
☐ Digital Flexion/Extension ☐ T ☐ I ☐ L ☐ R ☐ S
☐ Wrist
☐ Forearm Rotation
☐ Elbow Flexion / Extension
☐ Shoulder Abduction / Flexion

☐ Physical Measurements
☐ Edema Measurement
☐ Detailed ROM
☐ Return to Work Evaluation ☐ Limited ☐ Complete
☐ Full Computerized Hand Exam
☐ Grip and Pinch Strengths
☐ Semmes-Weinstein Monofilament Exam

☐ **Protocols**
☐ CMC Resection Arthroplasty
☐ Dupuytren's Fasciectomy
☐ Distal Radius Fracture
☐ Distal Radius External Fixator
☐ Ergonomic Instruction
☐ Extensor Tendon Repair Zone ______

☐ Extensor Tenolysis Zone ______
☐ Flexor Tendon Repair Zone ______
☐ Flexor Tenolysis Zone ______
☐ Job Site Analysis
☐ PIP Contracture / Sprain
☐ Proximal Humerous Fracture

☐ Rheumatoid Arthritis Education
☐ Rotator Cuff Repair
☐ Rotator Cuff Tendinitis
☐ Shoulder Arthroplasty
☐ Sympathetically Mediated Pain
☐ Work Hardening

NOTES

Letter of Medical Necessity:
I certify that the above prescribed equipment, its setup and related patient education are medically indicated and necessary to the accepted standards of medicine of this patient's condition.

Signed S. DeLeon Date 6/19/2017

Serafin DeLeon, MD

For your information, the Physical Therapists, Occupational Therapists and Athletic Trainers at IBJI are financially integrated. If you are referred to a clinician in IBJI for any related services, you may request and receive a referral for these services outside or independent of IBJI

ROF12

40720-NVC Gurnee IL
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Patient Appointment list for Levandoski, Cindy Account#: 040R840251462.
Report includes appointments with statuses of Void, Scheduled, Arrived, Rescheduled, Cancelled, No Show.

Date	Time	Appt. Status	Clinician	Location	Copay Collected	Date Created	Last Changed Date	Last Changed UserID
Jul 06, 2017	08:30 AM	Rescheduled	Almanza, PT , Stacy	40720-NVC Gurnee IL	$ .00	Jun 27, 2017	Jul 06, 2017	SELECT\escobedc
Jul 10, 2017	12:30 PM	Arrived	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 06, 2017	Jul 11, 2017	SELECT\leipoldt
Jul 12, 2017	09:30 AM	Void	Bastable, PTA , Todd	40720-NVC Gurnee IL	$ .00	Jul 10, 2017	Jul 11, 2017	SELECT\leipoldt
Jul 14, 2017	11:30 AM	Arrived	Bastable, PTA , Todd	40720-NVC Gurnee IL	$ .00	Jul 10, 2017	Jul 14, 2017	SELECT\JorRivera
Jul 18, 2017	03:00 PM	Arrived	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 17, 2017	Jul 18, 2017	SELECT\leipoldt
Jul 20, 2017	04:30 PM	Void	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 17, 2017	Jul 19, 2017	SELECT\escobedc
Jul 21, 2017	02:00 PM	Arrived	Bastable, PTA , Todd	40720-NVC Gurnee IL	$ .00	Jul 19, 2017	Jul 21, 2017	SELECT\JorRivera
Jul 25, 2017	03:30 PM	Scheduled	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 21, 2017	Jul 21, 2017	SELECT\JorRivera
Jul 27, 2017	04:30 PM	Scheduled	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 21, 2017	Jul 21, 2017	SELECT\JorRivera

TUES -3HRS LATE ST PER MMED

JULY 18TH 2HR

JULY 25TH 1HR

NovaCare Rehabilitation
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Jul 12, 2017	09:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Fri, Jul 14, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00

Additional Instructions:

TUESDAY JULY 18th - 300pm

THURSDAY JULY 20th - 430 pm

Thank you,
NovaCare Rehabilitation

NovaCare Rehabilitation
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Jul 12, 2017	09:60 AM	Workers Comp	Bastable, PTA , Todd	0.00
Fri, Jul 14, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00

Additional Instructions:

TUESDAY JULY 18th – 300pm

THURSDAY JULY 20th – 430 pm

Thank you,
NovaCare Rehabilitation

NovaCare Rehabilitation
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Aug 23, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 29, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 30, 2017	04:00 PM	Workers Comp	Bastable, PTA , Todd	0.00
Thu, Aug 31, 2017	12:00 PM	Workers Comp	Leipold, PT , Tracy	0.00

Additional Instructions:

Thank you,
NovaCare Rehabilitation

NovaCare Rehabilitation
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

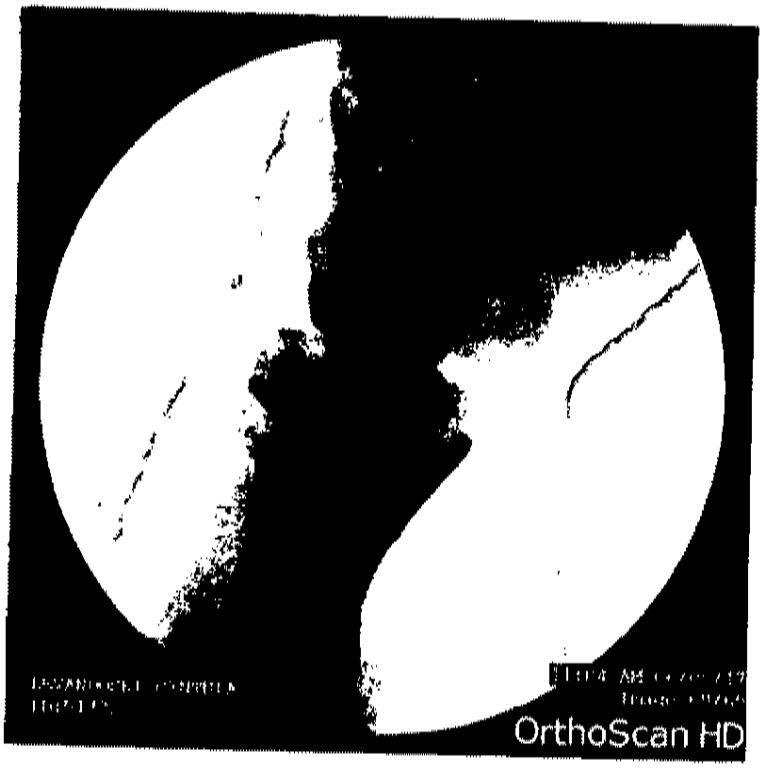
Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Tue, Aug 01, 2017	12:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
~~Wed, Aug 02, 2017~~	~~04:30 PM~~	Workers Comp	Bastable, PTA , Todd	0.00
Mon, Aug 07, 2017	09:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Wed, Aug 09, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 15, 2017	12:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 16, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Tue, Aug 22, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 23, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 29, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 30, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00

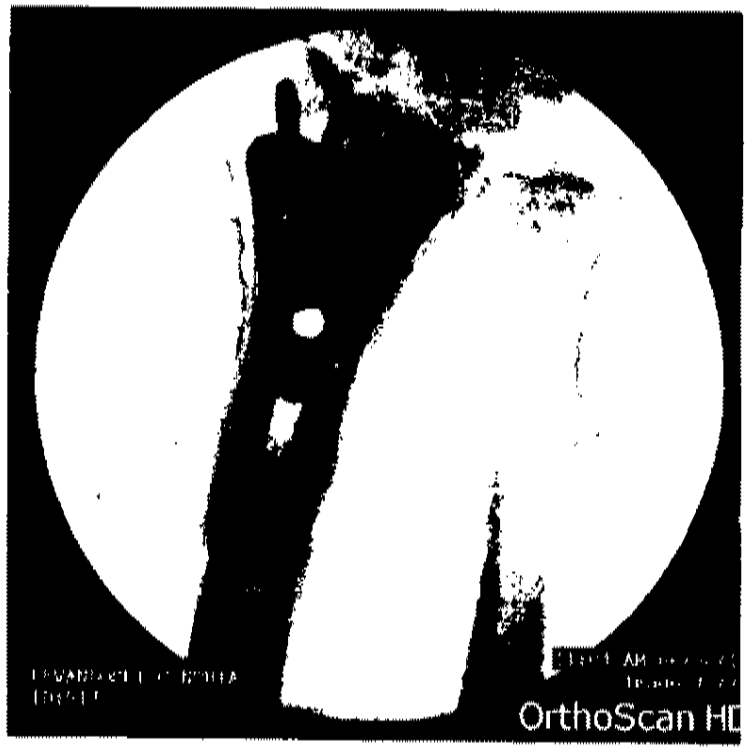
Additional Instructions:

Thank you,
NovaCare Rehabilitation

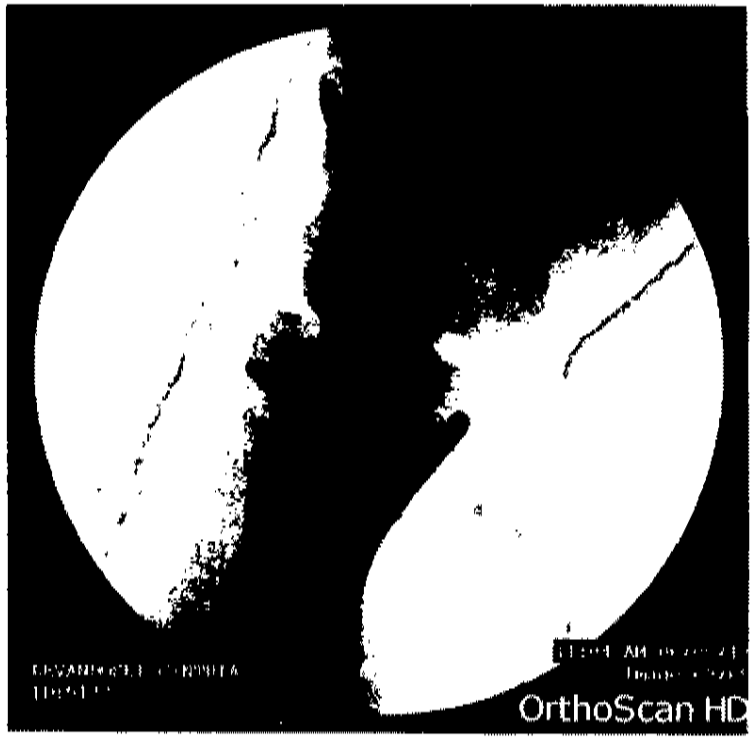
LEVANDOSKI^CYNTHIA
51732
2017-06-08 11:04:14



LEVANDOSKI^CYNTHIA
51732
2017-06-08 11:04:40



LEVANDOSKI^CYNTHIA
51732
2017-06-08 11:04:14



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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
08/15/2017	08:15 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

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Workers' Compensation Work Status Report

Date: 9/21/2017

Physician: S. DeLeon
Serafin DeLeon, MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware as well as possible triangular fibrocartilage complex tear.

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

☐ Employee can return to work as of _____ **without restrictions.**

☐ Employee can return to work as of _____ **with the restrictions** identified below which are expected to last through _____. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☒ Employee is **unable to return to work** as of 09/28/17 and is expected to be off of work through:
☐ _____(date) ☒ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day		☐ Walking	Not to exceed ____ hrs/day	
☐ Sitting	Not to exceed ____ hrs/day		☐ Climbing	Not to exceed ____ hrs/day	
☐ Kneeling/Squatting	Not to exceed ____ hrs/day		☐ Grasping	Not to exceed ____ hrs/day	
☐ Bending/Stooping	Not to exceed ____ hrs/day		☐ Squeezing	Not to exceed ____ hrs/day	
☐ Twisting	Not to exceed ____ hrs/day		☐ Reaching	Not to exceed ____ hrs/day	
☐ Pushing/Pulling	Not to exceed ____ hrs/day		☐ Overhead	Not to exceed ____ hrs/day	
☐ Lifting/Carrying	Not to exceed ____ hrs/day		☐ Keyboarding	Not to exceed ____ hrs/day	

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 10/06/17 Time: 8:45 AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☒ Surgery Recommended: left distal radius removal of hardware as well as an arthroscopy with possible triangular fibrocartilage complex debridement versus repair

☐ Rehab (PT/OT) Recommended: _____x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
10/06/2017	08:45 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

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Workers' Compensation Work Status Report

Date: 11/3/2017

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware as well as possible triangular fibrocartilage complex tear, s/p removal of hardware, arthroscopy & synovectomy

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17 DOS 9/28/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 11/3/17 **with the restrictions** identified below which are expected to last through **next appt**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☒ Not to exceed 5 lbs	☐ R	☒ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☒ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): ***NO REGISTER***

Expected Follow-up Services Include:

☒ Next Appointment Date: 11/3/17 Time: 8:15 AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez,CCMA

RF43

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Workers' Compensation Work Status Report

Date: 11/7/2017 *Updated*

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware and possible triangular fibrocartilage complex tear. s/p removal of hardware, arthroscopy & synovectomy

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17 DOS 9/28/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 11/3/17 **with the restrictions** identified below which are expected to last through **next appt** . If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☒ Not to exceed 5 lbs	☐ R	☒ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☒ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): ***NO REGISTER***

Expected Follow-up Services Include:

☒ Next Appointment Date: 12/01/17 Time: 8:15 AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Isabel Villarreal,CCMA

RF43

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Workers' Compensation Work Status Report

Date: 12/1/2017

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware and possible triangular fibrocartilage complex tear.

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17 DOS 9/28/17

s/p removal of hardware, arthroscopy & synovectomy

☒ Employee can return to work as of 12/1/17 **without restrictions.**

☐ Employee can return to work as of _____ **with the restrictions** identified below which are expected to last through _____. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 1/8/18 Time: 12:45PM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: ____ x per week for ____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez,CCMA

RF43

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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
12/01/2017	08:15 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

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Workers' Compensation Work Status Report

Date: 1/8/2018

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left wrist retained hardware and TFCC tear

Employer: Hobo

S/P removal of hardware as well as scar excision and left

Date of Injury: 5/22/17 Surgery:9/20/17

wrist arthroscopy and synovectomy

☒ Employee can return to work as of 1/8/18 **without restrictions.**

☐ Employee can return to work as of _____ **with the restrictions** identified below which are expected to last through _____. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day		☐ Walking	Not to exceed ____ hrs/day	
☐ Sitting	Not to exceed ____ hrs/day		☐ Climbing	Not to exceed ____ hrs/day	
☐ Kneeling/Squatting	Not to exceed ____ hrs/day		☐ Grasping	Not to exceed ____ hrs/day	
☐ Bending/Stooping	Not to exceed ____ hrs/day		☐ Squeezing	Not to exceed ____ hrs/day	
☐ Twisting	Not to exceed ____ hrs/day		☐ Reaching	Not to exceed ____ hrs/day	
☐ Pushing/Pulling	Not to exceed ____ hrs/day		☐ Overhead	Not to exceed ____ hrs/day	
☐ Lifting/Carrying	Not to exceed ____ hrs/day		☐ Keyboarding	Not to exceed ____ hrs/day	

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 2/2/18 Time: 7:45am at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Clairie Chicas, CCMA

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Workers' Compensation Work Status Report

Date: 2/16/2018

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left wrist retained hardware and TFCC tear

Employer: Hobo

s/p removal of hardware, scar excision, arthroscopy and

Date of Injury: 5/22/17 DOS 9/20/17 & 6/8/17

ECU tendonitis

☒ Employee can return to work as of 2/16/18 **without restrictions.**

☐ Employee can return to work as of _____ **with the restrictions** identified below which are expected to last through _____. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work *through:*
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day		☐ Walking	Not to exceed ____ hrs/day	
☐ Sitting	Not to exceed ____ hrs/day		☐ Climbing	Not to exceed ____ hrs/day	
☐ Kneeling/Squatting	Not to exceed ____ hrs/day		☐ Grasping	Not to exceed ____ hrs/day	
☐ Bending/Stooping	Not to exceed ____ hrs/day		☐ Squeezing	Not to exceed ____ hrs/day	
☐ Twisting	Not to exceed ____ hrs/day		☐ Reaching	Not to exceed ____ hrs/day	
☐ Pushing/Pulling	Not to exceed ____ hrs/day		☐ Overhead	Not to exceed ____ hrs/day	
☐ Lifting/Carrying	Not to exceed ____ hrs/day		☐ Keyboarding	Not to exceed ____ hrs/day	

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 3/16/18 Time: 8:15AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez, CCMA

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Serafin DeLeon, MD
350 S. Greenleaf, Ste 405~ Gurnee, IL 60031
Phone (847) 336-3335~ Fax (847) 336-3249

WORKERS' COMP WORK STATUS REPORT

Patient Name: Cynthia L Levandoski
Employer: Home Owner's Bargain Outlet
Occupation:
Diagnosis: Left wrist extensor carpi ulnaris tendinitis

DOV: 1/8/2019
MR#: 1520501
Date of Injury: 5/22/2017

☐ Employee can return to work as of _____ without restrictions.
☐ Employee can return to work as of _____ with restrictions as identified below, which are expected to last through _____. If modified duty meeting these restrictions is not available, the patient should be considered off work.
■ Employee is unable to return to work as of 1/14/2019 and is expected to be off of work through _____.
■ until next appointment (listed below) and will be assessed then.
OR: ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)
☐ until surgery. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Bending/Stooping	Not to exceed _____ hrs/day	☐ Overhead	Not to exceed _____ hrs/day
☐ Climbing	Not to exceed _____ hrs/day	☐ Power Tools or Vibratory Tools	Not to exceed _____ hrs/day
☐ Crawling	Not to exceed _____ hrs/day	☐ Pushing/Pulling	Not to exceed _____ hrs/day
☐ Exposure to Water/Oil/Dust	Not to exceed _____ hrs/day	☐ Reaching	Not to exceed _____ hrs/day
☐ Extreme Hot/Cold	Not to exceed _____ hrs/day	☐ Sitting	Not to exceed _____ hrs/day
☐ Grasping	Not to exceed _____ hrs/day	☐ Squeezing	Not to exceed _____ hrs/day
☐ Keyboarding	Not to exceed _____ hrs/day	☐ Standing	Not to exceed _____ hrs/day
☐ Kneeling/Squatting	Not to exceed _____ hrs/day	☐ Twisting	Not to exceed _____ hrs/day
☐ Lifting/Carrying	Not to exceed _____ hrs/day	☐ Walking	Not to exceed _____ hrs/day

No Work Involving		Lift/Carry/Push/Pull Restrictions		Misc. Restrictions
Hand/Wrist/Arm	☐ R ☐ L	Not to exceed _____ lbs	☐ R ☐ L	☐ Wear splint/brace/sling/cast at work
Leg	☐ R ☐ L	No lifting/carrying	☐ R ☐ L	☐ Sitting only
Foot/Ankle	☐ R ☐ L	No pushing/pulling	☐ R ☐ L	☐ Must use
Neck	☐	No Pinching	☐ R ☐ L	☐ Walking/standing as tolerated
Back	☐	No Grasping/squeezing	☐ R ☐ L	☐ No driving
Climbing Restrictions		**Weight Restrictions:**		☐ No operating heavy equip/machines
				☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:
■ Next appointment date: 1/21/2019 Time: 12:15 pm Location: Gurnee-350 S. Greenleaf, Ste 405B
☐ Diagnostic Studies Requested: _____
■ Surgery Recommended: left extensor carpi ulnaris release SURGERY DATE: 1/14/19
☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____.
☐ Referral to: _____
☐ NONE: *This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.*

S. DeLeon

Physician/Provider Digital Signature Note prepared by: Melissa Villalobos

Date: 1/8/2019

left extensor carpi ulnaris release.

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HAWTHORN SURGERY CENTER

Dr. DeLeon Hand, Wrist and Elbow
POST-OPERATIVE HOME CARE INSTRUCTIONS

Phone: (847)336-3335 | Fax: (847)336-3249 | www.ibji.com

1. **DIET:**
   - ☒ Begin with liquids and light foods – Ginger Ale, soup, jello, etc. Progress to a normal diet, if there is no nausea. If nausea and vomiting continue, stay on liquids and call your physician.
   - ☐ No restrictions on diet.

2. **MEDICATIONS:** ☒ **Resume all home medication(s), if applicable.**
   - ☐ Other instructions, if applicable: _____
   - ☒ Use prescription as directed. If you have any problems taking the prescription medication, notify your physician. When taking pain medications be careful walking and climbing stairs. Dizziness is not unusual.
     *Pain medications may cause constipation. You may need a stool softener such as Senokot or Colace.
   - ☒ Side effects information for new medications given.
   - ☐ You have been prescribed OxyContin. It is a very powerful pain medication. Take it for severe pain not relieved by the Norco alone. **You must wait 4 hours between taking doses of Norco and OxyContin.**

Due to the side effects of most pain medications, if you have been diagnosed with sleep apnea and are prescribed a CPAP/BiPAP, it is *STRONGLY* advised to be compliant with use post operatively to avoid complications.

3. **ACTIVITIES:**
   - ☒ Because of anesthesia, limit activities for 24 hours. Do not drive a motor vehicle, operate machinery, power tools or appliances. Do not make critical decisions. Do not sign any legal documents. Do not drink any alcoholic beverages.
   - ☐ Resume normal activities as tolerated
   - ☐ No activity restrictions
   - ☐ See additional instructions below/attached

4. **HAND THERAPY:**
   - ☐ None until instructed further.
   - ☑ Several times a day, try to bend and straighten your fingers and move your wrist and elbow to prevent stiffness.

5. **DRESSING CARE:**
   - ☒ You may remove your bandage in 5 days and get incision wet.
   - ☐ Do not remove your bandages. Wounds heal with the fewest problems if they are kept clean and dry. When bathing protect your bandage in a plastic bag.

6. **DANGER SIGNALS:**
   Excessive pain, bleeding, swelling, temperature over 101 degrees, if extremity becomes cold to touch/tingly/numb, or there are ANY OTHER PROBLEMS IN REGARD TO YOUR SURGERY, please call your physician immediately.

7. **FOLLOW-UP APPOINTMENTS:**
   - ☐ Post-operative appointment: 1 week Dr. DeLeon Location: _____

ADDITIONAL INSTRUCTIONS: _____

WE STRIVE FOR EXCELLENCE! IF YOU HAD A POSITIVE EXPERIENCE WHILE AT HAWTHORN SURGERY CENTER, PLEASE GIVE US RATINGS OF "STRONGLY AGREE" OR 9s AND 10s ON YOUR PATIENT SATISFACTION SURVEY!

A recovery room nurse will call you in a day or two. This is a routine call to find out how you are progressing after surgery. We wish you a pleasant and uneventful recovery.

Discharge instructions reviewed by _____ Date _____

X _____
Instructions understood by patient/authorized authority Date

FM-06355 (07/17)

PATIENT LABEL

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Serafin DeLeon, MD
350 S. Greenleaf, Ste 405~ Gurnee, IL 60031
Phone (847) 336-3335~ Fax (847) 336-3249

WORKERS' COMP WORK STATUS REPORT

Patient Name: Cynthia L Levandoski
Employer: Home Owner's Bargain Outlet
Occupation:
Diagnosis: Left wrist extensor carpi ulnaris tendinitis status post left wrist extensor carpi ulnaris release

DOV: 1/21/2019
MR#: 1520501
Date of Injury: 05/22/2017

☐ Employee can return to work as of _____ without restrictions.
☐ Employee can return to work as of _____ with restrictions as identified below, which are expected to last through _____. If modified duty meeting these restrictions is not available, the patient should be considered off work.
■ Employee is unable to return to work as of 1/21/2019 and is expected to be off of work through _____.
- ■ until next appointment (listed below) and will be assessed then.
- OR: ☐ ~~until diagnostic testing (listed below) is complete. (awaiting W/C approval)~~
- ☐ until surgery. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Bending/Stooping	Not to exceed _____ hrs/day	☐ Overhead	Not to exceed _____ hrs/day
☐ Climbing	Not to exceed _____ hrs/day	☐ Power Tools or Vibratory Tools	Not to exceed _____ hrs/day
☐ Crawling	Not to exceed _____ hrs/day	☐ Pushing/Pulling	Not to exceed _____ hrs/day
☐ Exposure to Water/Oil/Dust	Not to exceed _____ hrs/day	☐ Reaching	Not to exceed _____ hrs/day
☐ Extreme Hot/Cold	Not to exceed _____ hrs/day	☐ Sitting	Not to exceed _____ hrs/day
☐ Grasping	Not to exceed _____ hrs/day	☐ Squeezing	Not to exceed _____ hrs/day
☐ Keyboarding	Not to exceed _____ hrs/day	☐ Standing	Not to exceed _____ hrs/day
☐ Kneeling/Squatting	Not to exceed _____ hrs/day	☐ Twisting	Not to exceed _____ hrs/day
☐ Lifting/Carrying	Not to exceed _____ hrs/day	☐ Walking	Not to exceed _____ hrs/day

No Work Involving	**Lift/Carry/Push/Pull Restrictions**	**Misc. Restrictions**
Hand/Wrist/Arm ☐ R ☐ L	Not to exceed _____ lbs ☐ R ☐ L	☐ Wear splint/brace/sling/cast at work
Leg ☐ R ☐ L	No lifting/carrying ☐ R ☐ L	☐ Sitting only
Foot/Ankle ☐ R ☐ L	No pushing/pulling ☐ R ☐ L	☐ Must use
Neck ☐	No Pinching ☐ R ☐ L	☐ Walking/standing as tolerated
Back ☐	No Grasping/squeezing ☐ R ☐ L	☐ No driving
Climbing Restrictions	**Weight Restrictions:**	☐ No operating heavy equip/machines
		☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:
■ Next appointment date: 2/20/2019 Time: 7:45 am Location: Gurnee-350 S. Greenleaf, Ste 405
☐ Diagnostic Studies Requested: _____
☐ Surgery Recommended: _____
☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____.
☐ Referral to: _____
☐ NONE: This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

S. DeJesus

Physician/Provider Digital Signature Note prepared by: Isabel Villarreal CCMA Date: 1/21/2019

Northern District of Illinois
Claims Register

18-30043 Belvidere Associates LLC

Honorable Judge: Jacqueline P. Cox **Chapter:** 11

Office: Eastern Division **Last Date to file claims:**

Trustee: **Last Date to file (Govt):**

Creditor: (27477857)
Cynthia Levandoski
c/o Fonfrias Law Group
125 S Wacker Dr. #300
Chicago, IL 60606

Claim No: 65
Original Filed Date: 01/24/2019
Original Entered Date: 01/24/2019
Last Amendment Filed: 01/28/2019
Last Amendment Entered: 01/28/2019

Status:
Filed by: CR
Entered by: Richard G. Fonfrias
Modified:

Amount claimed: $75000.00

History:

Details	65-1	01/24/2019	Claim #65 filed by Cynthia Levandoski, Amount claimed: $75000.00 (Fonfrias, Richard)
Details	65-2	01/28/2019	Amended Claim #65 filed by Cynthia Levandoski, Amount claimed: $75000.00 (Fonfrias, Richard)

Description:

Remarks:

Claims Register Summary

Case Name: Belvidere Associates LLC
Case Number: 18-30043
Chapter: 11
Date Filed: 10/25/2018
Total Number Of Claims: 1

Total Amount Claimed*	$75000.00
Total Amount Allowed*	

*Includes general unsecured claims

The values are reflective of the data entered. Always refer to claim documents for actual amounts.

	Claimed	Allowed
Secured		
Priority		
Administrative		

Fill in this information to identify the case:

Debtor 1 Belvidere Associates LLC

Debtor 2 (Spouse, if filing) _____

United States Bankruptcy Court for the: Northern District of Illinois

Case number 18-30043

Official Form 410

Proof of Claim

04/16

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**

Cynthia Levandoski
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor _____

2. **Has this claim been acquired from someone else?**

☑ No
☐ Yes. From whom? _____

3. **Where should notices and payments to the creditor be sent?**

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent?** (if different)
Cynthia Levandoski c/o Fonfrias Law Name	_____ Name
125 S Wacker Dr. #300 Number Street	_____ Number Street
Chicago IL 60606 City State ZIP Code	_____ City State ZIP Code
Contact phone 312-969-0730	Contact phone _____
Contact email rfonfrias2025@gmail.com	Contact email _____

Uniform claim identifier for electronic payments in chapter 13 (if you use one):

_ _

4. **Does this claim amend one already filed?**

☑ No
☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**

☑ No
☐ Yes. Who made the earlier filing? _____

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
☑ No
☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ____ ____ ____ ____

7. **How much is the claim?** $ 75,000.00 . **Does this amount include interest or other charges?**
☐ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**
Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.
Work Injury as employee of Debtor

9. **Is all or part of the claim secured?**
☑ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim.*
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection: _____
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: $_____
Amount of the claim that is secured: $_____
Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amounts should match the amount in line 7.)
Amount necessary to cure any default as of the date of the petition: $_____
Annual Interest Rate (when case was filed)_____%
☐ Fixed
☐ Variable

10. **Is this claim based on a lease?**
☑ No
☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**
☑ No
☐ Yes. Identify the property: _____

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check one:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐ Up to $2,850* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$_____
☐ Wages, salaries, or commissions (up to $12,850*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$_____
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$_____
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$_____
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$_____

* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☐ I am the creditor.
☑ I am the creditor's attorney or authorized agent.
☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 01/24/2019
MM / DD / YYYY

Signature

Print the name of the person who is completing and signing this claim:

Name: Heath S. Isaacs
First name Middle name Last name

Title: Paralegal

Company: Fonfrias Law Group
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 125 S Wacker Dr., #300
Number Street

Chicago IL 60606
City State ZIP Code

Contact phone: 801-726-7704 Email: heath@casedriver.com

ILLINOIS WORKERS' COMPENSATION COMMISSION

APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

ATTENTION. Please type or print. Answer all questions. File three copies of this form.

Workers' Compensation Act X Occupational Diseases Act ___ Fatal case? No X Yes ___ Date of death ___

OCT 19 2017

Cynthia Levandoski
Employee/Petitioner

Case # 17WC030779
(Office use only)

v.

Home Owners Bargain Outlet
Belvidere Associates, LLC
Employer/Respondent

Location of accident or last exposure: Waukegan, IL (City, State)

Cynthia Levandoski	2206 Waverly Place	Waukegan	IL	60084
Injured employee's name [1]	Street address	City, State, Zip code		
Home Owners Bargain Outlet	2650 Belvidere Road	Waukegan	IL	60085
Belvidere Associates, LLC	2650 Belvidere Road	Waukegan	IL	60085
Employer's name	Street address	City, State, Zip code		

Employee information: State Employee? Yes ___ No X Male ___ Female X Married ___ Single X

Dependents under age 18 0 Birthdate 05/03/1963 Average weekly wage $ 630.00

Date of accident [2] 05/22/2017 The employer was notified of the accident orally X in writing ___

How did the accident occur? Pulling out a bedding set.

What part of the body was affected? Left hand/wrist.

What is the nature of the injury? To be determined. Return-to-work date [3] ___

Is a *Petition for an Immediate Hearing* attached? Yes ___ No X

Is the injured employee currently receiving temporary total disability benefits? Yes ___ No X

If a prior application was ever filed for this employee, list the case number and its status ___

ILL WORKERS' COMP COMM 2017 OCT 17 AM 8:30

ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's *Handbook on Workers' Compensation and Occupational Diseases* [4] for more information.

Cynthia Levandoski
Signature of petitioner

8/28/17
Date

APPEARANCE OF PETITIONER'S ATTORNEY

Please attach a copy of the *Attorney Representation Agreement.*

Signature of attorney

3416 W. Elm Street
Street address

Mark J. Vogg 1919
Attorney's name and IC code #[5] (please print)

McHenry IL 60050
City, State, Zip code

Law Offices of Thomas J. Popovich
Firm name

815-344-3797
Telephone number

E-mail address

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.
If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, Mark J. Vogg, affirm that I delivered ____ mailed with proper postage X

in the city of McHenry, IL a copy of this form

at 5:00 ~~AM~~/PM on 10-10-17 to the respondent listed on this application and to each additional party, if any, at the address listed below.

Signature of person completing *Proof of Service*

Signed and sworn to before me on _____

Notary Public

[1] In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee. Please complete information related to age, etc., for the injured employee.

[2] This may be the date of the accident, last exposure, disability, or death.

[3] If the employee has not returned to work, leave this space blank.

[4] The Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any of the Commission offices listed on the other side of this form.

[5] The Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

VISTA HEALTH SYSTEM

Corporate Health Services

WORK STATUS REPORT

EMPLOYEE NAME: Cynthia Levandoski

EMPLOYER: [illegible] Date: 5/10/17 Admit Time: 1:30

WORK STATUS

☐ Regular Work as of: _____
☐ Off Work Rest of Today Only
☐ Off Work Until: _____
☐ Work Status to be determined by Specialist
☐ Can Work with the Restrictions Specified Below:

LIFTING/BENDING

☐ No lifting, pushing or pulling over _____ lbs
☐ No repetitive lifting
☐ No lifting above the shoulder level
☐ Gradually increase lifting to _____ lbs over the next _____ days
☐ Limit bending, stooping and twisting

ARMS/SHOULDERS

☐ No work using RIGHT/LEFT arm
☐ Limited use of RIGHT/LEFT arm
☐ No reaching while lifting
☐ No working with RIGHT/LEFT arm above chest level
☐ Wear sling for _____ days

WALK/SIT/STAND

☐ Sitting job, minimum of walking
☐ Uses crutches
☐ Get up from sitting position every half hour
☐ Alternate standing/sitting positions every
☐ half hour ☐ as needed

HANDS/WRISTS

☐ No use of RIGHT/LEFT hand
☐ Limit use of RIGHT/LEFT hand
☐ No tight gripping with RIGHT/LEFT hand
☐ No repeat twisting/bending of RIGHT/LEFT wrist
☐ Wear splint on RIGHT/LEFT WRIST/FINGER

SQUAT/CLIMB

☐ No squatting or kneeling
☐ No climbing
☐ Ground level work only

NECK

☐ Avoid repeated neck motions

SKIN

☐ Keep wound clean and dry
☐ Keep covered at work
☐ Avoid exposure to:

MACHINE/VEHICLE

☐ No hazardous or fast moving machinery
☐ No driving

PATIENT INSTRUCTIONS

☐ Start PT/OT
☐ Exercises/stretches as instructed
☒ Ibuprofen: 600 mg; every 6 hrs; take with food
☐ Bacitracin to wound twice daily
☐ Cyclobenzaprine: _____ mg; every _____ hrs; take at bedtime ONLY; DO NOT drive within 8 hrs of each dose – may make drowsy

ADDITIONAL INSTRUCTIONS

DIAGNOSIS: Lacerated wound forearm

MD/PA Signature: [signature]

Next Appointment:	Date: _____ Time: _____ ☐ DISCHARGED
Physical/Occupational Therapy	Date: _____ Time: _____
Referral to Specialist	Doctor: PCP Date: _____ Time: _____ Location: Medical clinic Phone: _____
Drug Screen	☐ YES ☐ NO ☐ N/A ☐ After care instructions given and discussed Discharge Time: _____

Call Corporate Health at 847.360.2860 or 847.356.4746

Vista West 2615Washington St., Waukegan Vista Lindenhurst 1050 Red Oak Lane, Lindenhurst

SIGNATURES – PATIENT [signature] RN/TECH [signature]

WHITE – CHS YELLOW – COMPANY PINK – PATIENT

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Workers' Compensation Work Status Report

Date: 5/24/2017 **Physician:** S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia **Diagnosis:** Left distal radius fracture

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 5-29-17 **with the restrictions** identified below which are expected to last through **5-30-17**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☒ Employee is **unable to return to work** as of 5-24-17 and is expected to be off of work through:
☒ 5-28-17 (date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☒ No lifting/carrying	☐ R	☒ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions
- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 5-30-17 Time: 7:40am at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Krystal Perez

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Workers' Compensation Work Status Report

Date: 5/30/2017 **Physician:** S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia **Diagnosis:** left distal radius fracture

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 5-30-17 **with the restrictions** identified below which are expected to last through **pending surgery**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☒ No lifting/carrying	☐ R	☒ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions
- ☒ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): Patient may not work at the register

Expected Follow-up Services Include:

☒ Next Appointment Date: pending surgery Time: _____ at Select Office

☐ Diagnostic Studies Requested: _____

☒ Surgery Recommended: left distal radius open reduction and internal fixation; PENDING APPROVAL

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Krystal Perez

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Hawthorn Surgery Center

Patient Centered. Extraordinary Care.

To the Patient or Guardian:

Your physician may dispense an orthopedic soft good or bracing device as part of your treatment at Hawthorn Surgical Center. These products include but are not limited to:

X Arm Sling	_____ Shoulder Abduction Sling
_____ CAM Walker Boot	_____ Crutches
_____ Knee Immobilizer	_____ Post-Op Shoe/APB
_____ TED Compression Hose	_____ 4-Prong Walker

These products are very common conservative orthopedic devices covered by most insurance companies and Medicare. The charges for a soft good or bracing device will be billed directly to your insurance company by Specialty Medical Services, INC. not Hawthorn Surgical Center. Payment for the soft good or bracing device will be made according to your members plan benefits. For example, you may be charged a deductible for the soft good or bracing device from Specialty Medical Services, INC.

If you have any questions regarding you bill or insurance claim, please contact you insurance carrier directly or Specialty Medical Services, Inc., at the number below. There is no financial interest or other business association between Specialty Medical Services, Inc. and Hawthorn Surgery Center.

Please read the assignment of insurance benefits for the soft good or bracing device that you may receive from you physician, then sign below.

Specialty Medical Services, Inc. has instituted privacy practice that are in compliance with the Health Insurance Portability and Accountability Act.

The rules in our office are intended to safeguard you private health information. We disclose only that information necessary to process your claim for benefits and payment. This include: demographic information, the nature of treatment requiring our product and pertinent information necessary to process your claim with your insurance carrier/responsible party for payment. As it is a business associate, Specialty Medical Services, Inc. complies with the HIPAA guidelines presented to you at the facility prescribing your orthotic, soft good or durable medical equipment.

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION, RELEASE OF MEDICAL INFORMATION, AND BENEFIT ASSIGNMENT DISCLOSURE FORM

SPECIALTY MEDICAL SERVICES, INC. is the supplier of the soft good, orthotic or bracing device prescribed by my physician at this facility. I authorize the release of my medical information necessary to process the resulting claim for the product(s) provided to me. Additionally, I authorize assignment of my insurance benefit to Specialty Medical Service, Inc. **I understand that I will be responsible for any co-payment, deductible or non-covered expenses that may result from this billing.**

Patient/ Guardian Signature: X [signature] Date: 6.8.17

Physician Signature: V.O. per Dr. DeLeon Date: 6.8.17

SPECIALTY MEDICAL SERVICES, INC

479 Business Center Dr.

Mount Prospect, IL 60056

(847) 720-4310 – Billing Department

Specialty Medical keep the original- one copy to patient, one copy remains in patient's chart

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Workers' Compensation Work Status Report

Date: 6/19/2017 **Physician:** S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia **Diagnosis:** Status Post Left ORIF of 3-Part Intra-Articular

Employer: Home Owner's Bargain Outlet Distal Radius Fracture

Date of Injury: 5/22/17 DOS: 6/8/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 6/26/17 **with the restrictions** identified below which are expected to last through **NEXT APPT**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☒ Employee is **unable to return to work** as of 6/19/17 and is expected to be off of work through:
☒ 6/25/17 (date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☒ No lifting/carrying	☐ R	☒ L
☒ No pushing/pulling	☐ R	☒ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): No use of arm sling

Expected Follow-up Services Include:

☒ Next Appointment Date: 7/17/17 Time: 12:15PM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☒ Rehab (PT/OT) Recommended: 2 x per week for 4 weeks starting pending WC approval

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Ofelia Diaz, CCMA

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Workers' Compensation Work Status Report

Date: 7/17/2017

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left three-part intraarticular distal radius Fracture S/P Open Reduction Internal Fixation

Employer: Home Owner's Bargain Outlet

Date of Injury: 5/22/17 DOS: 6/8/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 7/17/17 **with the restrictions** identified below which are expected to last through **8/15/17**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____ (date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☒ Not to exceed 5 lbs	☐ R	☒ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions
- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 8/15/17 Time: 8:15AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Clairie Chicas, CCMA

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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
07/17/2017	12:15 pm	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

Create Date: 6/19/2017 Due Date: 7/19/2017
Procedure: OT Facility: IBJI Rehab Gurnee
Ordering Provider: Serafin DeLeon - NPI # 1326091414

ILLINOIS BONE AND JOINT INSTITUTE, LLC
OCCUPATIONAL THERAPY ORDER

☐ Right ☒ Left

Patient Name: Levandoski, Cynthia Patient ID: 1520501 Diagnosis:

Treatment Frequency: ☐ x1 ☒ x2 ☐ x3 per week Treatment Duration: ☐ 1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☒ weeks ☐ months

SPLINT FABRICATION

☐ Right ☒ Left Notes:

- ☐ Hand based
- ☐ Forearm based
- ☐ Dorsal
- ☐ Volar
- ☐ Static
- ☐ Dynamic
  - ☐ Ext/Flex
  - ☐ Pro/Sup

- ☐ Fingertip Protector ☐ T ☐ I ☐ L ☐ R ☐ S
- ☐ Mallet Finger Splint ☐ T ☐ I ☐ L ☐ R ☐ S
- ☐ Ulnar Gutter Splint ☐ T ☐ I ☐ L ☐ R ☐ S
- ☐ Radial Gutter: include ☐ T ☐ I ☐ L ☐ R ☐ S
- ☐ Dorsal Blocking: include ☐ T ☐ I ☐ L ☐ R ☐ S
- ☐ Short Opponens Splint ☐ include IP joint
- ☐ Long Opponens Splint ☐ Exclude IP joint
- ☐ Wrist Splint
- ☐ Elbow (arm to wrist) ☐ Other: _____

- ☐ DIPs ☐ flex ☐ ext
- ☐ PIPs ☐ flex ☐ ext
- ☐ MCPs ☐ flex ☐ ext
- ☐ Wrist ☐ flex ☐ ext
- ☐ Forearm ☐ pro ☐ sup
- ☐ Elbow ☐ flex ☐ sup

THERAPY

☐ Right ☒ Left
☐ Elbow ☒ Wrist ☐ MCPs ☐ PIPs ☐ DIPs ☐ Thumb ☐ Index ☐ Long ☐ Ring ☐ Small

☐ Range of Motion
- ☐ Unlimited Mobilization
- ☐ Specific Goals
  - ☐ Active
  - ☐ Passive
  - ☐ Flexion
  - ☐ Extension
  - ☐ Pronation
  - ☐ Supination
  - ☐ Internal / External Rotation
  - ☐ Abduction / Forward Flexion

☒ Evaluate and Treat

☐ Soft Tissue Care
- ☐ Cryotherapy
- ☐ Desensitization
- ☐ Edema Control
- ☐ Electrical Stim
- ☐ Fluidotherapy
- ☐ Friction Massage
- ☐ Iontophoresis
- ☐ Scar Massage
- ☐ TENS
- ☐ Ultrasound
- ☐ Wound Care

☐ Strengthening
- ☐ Digital Flexion/Extension ☐ T ☐ I ☐ L ☐ R ☐ S
- ☐ Wrist
- ☐ Forearm Rotation
- ☐ Elbow Flexion / Extension
- ☐ Shoulder Abduction / Flexion

- ☐ Physical Measurements
  - ☐ Edema Measurement
  - ☐ Detailed ROM
  - ☐ Return to Work Evaluation ☐ Limited ☐ Complete
  - ☐ Full Computerized Hand Exam
  - ☐ Grip and Pinch Strengths
  - ☐ Semmes-Weinstein Monofilament Exam

☐ Protocols
- ☐ CMC Resection Arthroplasty
- ☐ Dupuytren's Fasciectomy
- ☐ Distal Radius Fracture
- ☐ Distal Radius External Fixator
- ☐ Ergonomic Instruction
- ☐ Extensor Tendon Repair Zone
- ☐ Extensor Tenolysis Zone _____
- ☐ Flexor Tendon Repair Zone _____
- ☐ Flexor Tenolysis Zone _____
- ☐ Job Site Analysis
- ☐ PIP Contracture / Sprain
- ☐ Proximal Humerous Fracture
- ☐ Rheumatoid Arthritis Education
- ☐ Rotator Cuff Repair
- ☐ Rotator Cuff Tendinitis
- ☐ Shoulder Arthroplasty
- ☐ Sympathetically Mediated Pain
- ☐ Work Hardening

NOTES

Letter of Medical Necessity:
I certify that the above prescribed equipment, its setup and related patient education are medically indicated and necessary to the accepted standards of medicine of this patient's condition.

Signed S. DeLeon Date 6/19/2017

Serafin DeLeon, MD

For your information, the Physical Therapists, Occupational Therapists and Athletic Trainers at IBJI are financially integrated. If you are referred to a clinician in IBJI for any related services, you may request and receive a referral for these services outside or independent of IBJI

40720-NVC Gurnee IL
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Patient Appointment list for Levandoski, Cindy Account#: 040R840251462.
Report includes appointments with statuses of Void, Scheduled, Arrived, Rescheduled, Cancelled, No Show.

Date	Time	Appt. Status	Clinician	Location	Copay Collected	Date Created	Last Changed Date	Last Changed UserID
Jul 06, 2017	08:30 AM	Rescheduled	Almanza, PT , Stacy	40720-NVC Gurnee IL	$ .00	Jun 27, 2017	Jul 06, 2017	SELECT\escobedc
Jul 10, 2017	12:30 PM	Arrived	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 06, 2017	Jul 11, 2017	SELECT\leipoldt
Jul 12, 2017	09:30 AM	Void	Bastable, PTA , Todd	40720-NVC Gurnee IL	$ .00	Jul 10, 2017	Jul 11, 2017	SELECT\leipoldt
Jul 14, 2017	11:30 AM	Arrived	Bastable, PTA , Todd	40720-NVC Gurnee IL	$ .00	Jul 10, 2017	Jul 14, 2017	SELECT\JorRivera
Jul 18, 2017	03:00 PM	Arrived	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 17, 2017	Jul 18, 2017	SELECT\leipoldt
Jul 20, 2017	04:30 PM	Void	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 17, 2017	Jul 19, 2017	SELECT\escobedc
Jul 21, 2017	02:00 PM	Arrived	Bastable, PTA , Todd	40720-NVC Gurnee IL	$ .00	Jul 19, 2017	Jul 21, 2017	SELECT\JorRivera
Jul 25, 2017	03:30 PM	Scheduled	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 21, 2017	Jul 21, 2017	SELECT\JorRivera
Jul 27, 2017	04:30 PM	Scheduled	Leipold, PT , Tracy	40720-NVC Gurnee IL	$ .00	Jul 21, 2017	Jul 21, 2017	SELECT\JorRivera

TUES - 3 HRS LATE ST PER MMED

JULY 18TH 2 HR

JULY 25TH 1 HR

NovaCare Rehabilitation
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Jul 12, 2017	09:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Fri, Jul 14, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00

Additional Instructions:

TUESDAY July 18th – 300pm

THURSDAY July 20th – 430 pm

Thank you,
NovaCare Rehabilitation

NovaCare Rehabilitation
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Jul 12, 2017	09:60 AM	Workers Comp	Bastable, PTA , Todd	0.00
Fri, Jul 14, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00

Additional Instructions:

TUESDAY JULY 18th – 300pm

THURSDAY JULY 20th – 430 pm

Thank you,
NovaCare Rehabilitation

NovaCare Rehabilitation
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Aug 23, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 29, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 30, 2017	04:00 PM	Workers Comp	Bastable, PTA , Todd	0.00
Thu, Aug 31, 2017	12:00 PM	Workers Comp	Leipold, PT , Tracy	0.00

Additional Instructions:

Thank you,
NovaCare Rehabilitation

NovaCare Rehabilitation
15 Tower Court, Suite 235
Gurnee , IL 60031
Phone: (847) 336-7468
Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

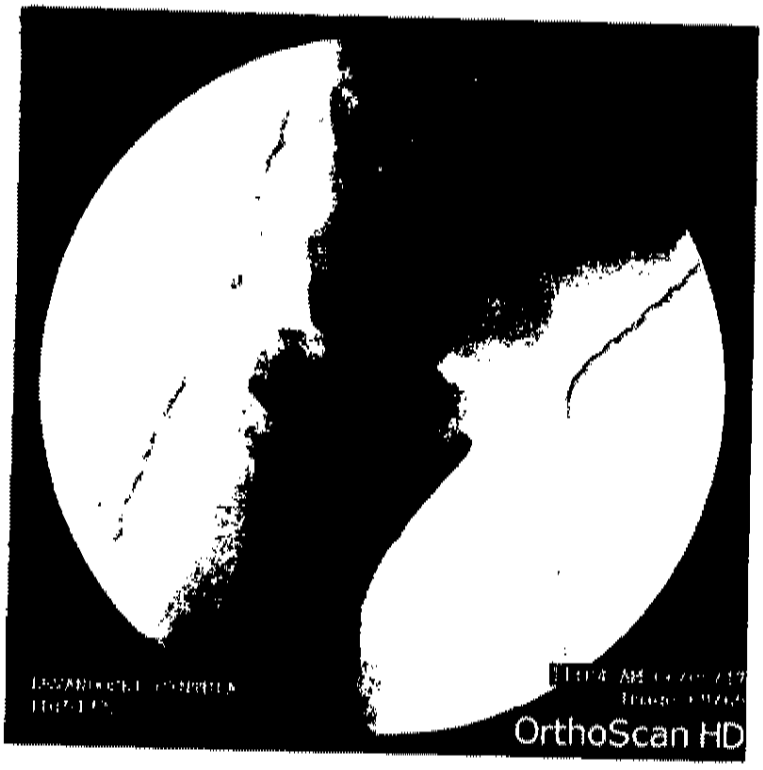
Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Tue, Aug 01, 2017	12:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
~~Wed, Aug 02, 2017~~	~~04:30 PM~~	Workers Comp	Bastable, PTA , Todd	0.00
Mon, Aug 07, 2017	09:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Wed, Aug 09, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 15, 2017	12:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 16, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Tue, Aug 22, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 23, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 29, 2017	04:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 30, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00

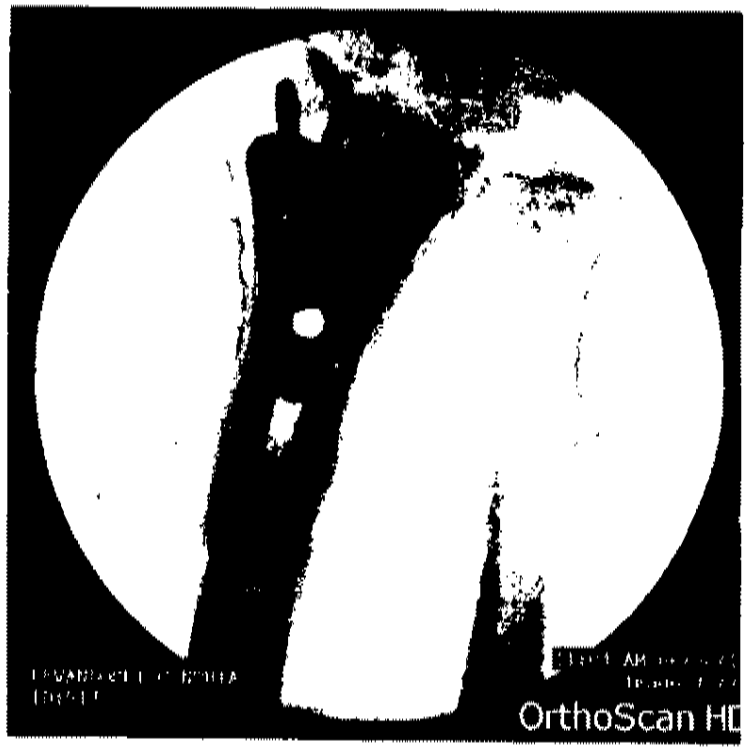
Additional Instructions:

Thank you,
NovaCare Rehabilitation

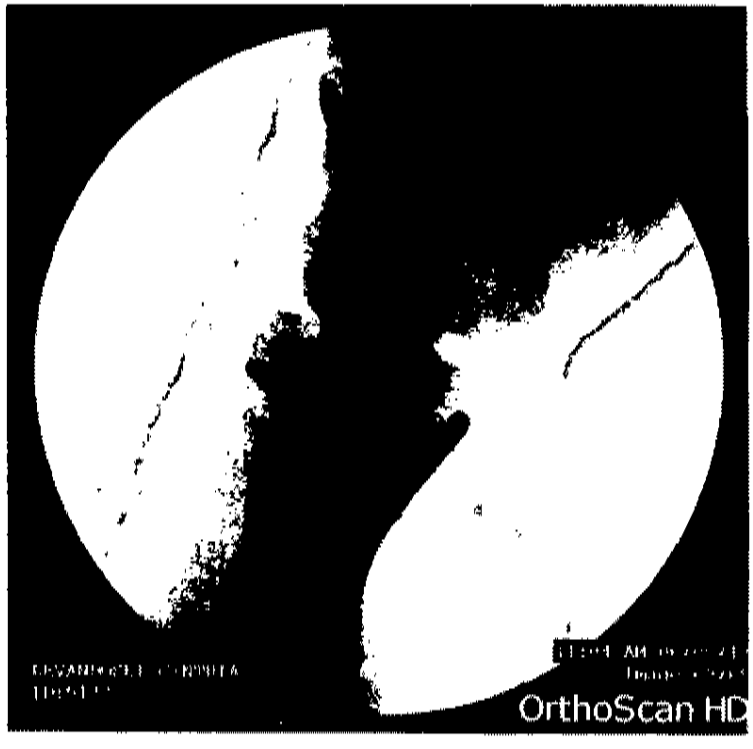
LEVANDOSKI^CYNTHIA
51732
2017-06-08 11:04:14



LEVANDOSKI^CYNTHIA
51732
2017-06-08 11:04:40



LEVANDOSKI^CYNTHIA
51732
2017-06-08 11:04:14



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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
08/15/2017	08:15 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

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Workers' Compensation Work Status Report

Date: 9/21/2017

Physician: Serafin DeLeon, MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware as well as possible triangular fibrocartilage complex tear.

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17

☐ Employee can return to work as of _____ **without restrictions.**

☐ Employee can return to work as of _____ **with the restrictions** identified below which are expected to last through _____. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☒ Employee is **unable to return to work** as of 09/28/17 and is expected to be off of work through:
☐ _____(date) ☒ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day		☐ Walking	Not to exceed ____ hrs/day	
☐ Sitting	Not to exceed ____ hrs/day		☐ Climbing	Not to exceed ____ hrs/day	
☐ Kneeling/Squatting	Not to exceed ____ hrs/day		☐ Grasping	Not to exceed ____ hrs/day	
☐ Bending/Stooping	Not to exceed ____ hrs/day		☐ Squeezing	Not to exceed ____ hrs/day	
☐ Twisting	Not to exceed ____ hrs/day		☐ Reaching	Not to exceed ____ hrs/day	
☐ Pushing/Pulling	Not to exceed ____ hrs/day		☐ Overhead	Not to exceed ____ hrs/day	
☐ Lifting/Carrying	Not to exceed ____ hrs/day		☐ Keyboarding	Not to exceed ____ hrs/day	

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 10/06/17 Time: 8:45 AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☒ Surgery Recommended: left distal radius removal of hardware as well as an arthroscopy with possible triangular fibrocartilage complex debridement versus repair

☐ Rehab (PT/OT) Recommended: _____x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
10/06/2017	08:45 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

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Workers' Compensation Work Status Report

Date: 11/3/2017 **Physician:** S. DeLeon Serafin DeLeon,MD

Name: Levandoski, Cynthia **Diagnosis:** Left distal radius retained hardware as well as possible triangular fibrocartilage complex tear.

Employer: Home Owner's Bargain Outlet s/p removal of hardware, arthroscopy & synovectomy

Date of Injury: 05/22/17 DOS 9/28/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 11/3/17 **with the restrictions** identified below which are expected to last through **next appt**. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☒ Not to exceed 5 lbs	☐ R	☒ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☒ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): ***NO REGISTER***

Expected Follow-up Services Include:

☒ Next Appointment Date: 11/3/17 Time: 8:15 AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez,CCMA

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Workers' Compensation Work Status Report

Date: 11/7/2017 *Updated*

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware and possible triangular fibrocartilage complex tear. s/p removal of hardware, arthroscopy & synovectomy

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17 DOS 9/28/17

☐ Employee can return to work as of _____ **without restrictions.**

☒ Employee can return to work as of 11/3/17 **with the restrictions** identified below which are expected to last through **next appt** . If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☒ Not to exceed 5 lbs	☐ R	☒ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☒ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): ***NO REGISTER***

Expected Follow-up Services Include:

☒ Next Appointment Date: 12/01/17 Time: 8:15 AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Isabel Villarreal,CCMA

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Workers' Compensation Work Status Report

Date: 12/1/2017

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left distal radius retained hardware and possible triangular fibrocartilage complex tear.

Employer: Home Owner's Bargain Outlet

Date of Injury: 05/22/17 DOS 9/28/17

s/p removal of hardware, arthroscopy & synovectomy

☒ Employee can return to work as of 12/1/17 **without restrictions.**

☐ Employee can return to work as of _____ **with the restrictions** identified below which are expected to last through _____. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day	☐ Walking	Not to exceed ____ hrs/day
☐ Sitting	Not to exceed ____ hrs/day	☐ Climbing	Not to exceed ____ hrs/day
☐ Kneeling/Squatting	Not to exceed ____ hrs/day	☐ Grasping	Not to exceed ____ hrs/day
☐ Bending/Stooping	Not to exceed ____ hrs/day	☐ Squeezing	Not to exceed ____ hrs/day
☐ Twisting	Not to exceed ____ hrs/day	☐ Reaching	Not to exceed ____ hrs/day
☐ Pushing/Pulling	Not to exceed ____ hrs/day	☐ Overhead	Not to exceed ____ hrs/day
☐ Lifting/Carrying	Not to exceed ____ hrs/day	☐ Keyboarding	Not to exceed ____ hrs/day

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions
- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 1/8/18 Time: 12:45PM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: ____ x per week for ____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez,CCMA

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Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
12/01/2017	08:15 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-336-3335	Deleon MD, Serafin M

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

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Workers' Compensation Work Status Report

Date: 1/8/2018

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left wrist retained hardware and TFCC tear

Employer: Hobo

S/P removal of hardware as well as scar excision and left

Date of Injury: 5/22/17 Surgery:9/20/17

wrist arthroscopy and synovectomy

☒ Employee can return to work as of 1/8/18 **without restrictions.**

☐ Employee can return to work as of _____ **with the restrictions** identified below which are expected to last through _____. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work through:
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day		☐ Walking	Not to exceed ____ hrs/day	
☐ Sitting	Not to exceed ____ hrs/day		☐ Climbing	Not to exceed ____ hrs/day	
☐ Kneeling/Squatting	Not to exceed ____ hrs/day		☐ Grasping	Not to exceed ____ hrs/day	
☐ Bending/Stooping	Not to exceed ____ hrs/day		☐ Squeezing	Not to exceed ____ hrs/day	
☐ Twisting	Not to exceed ____ hrs/day		☐ Reaching	Not to exceed ____ hrs/day	
☐ Pushing/Pulling	Not to exceed ____ hrs/day		☐ Overhead	Not to exceed ____ hrs/day	
☐ Lifting/Carrying	Not to exceed ____ hrs/day		☐ Keyboarding	Not to exceed ____ hrs/day	

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 2/2/18 Time: 7:45am at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Clairie Chicas, CCMA

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Workers' Compensation Work Status Report

Date: 2/16/2018

Physician: S. DeLeon
Serafin DeLeon,MD

Name: Levandoski, Cynthia

Diagnosis: Left wrist retained hardware and TFCC tear s/p removal of hardware, scar excision, arthroscopy and ECU tendonitis

Employer: Hobo

Date of Injury: 5/22/17 DOS 9/20/17 & 6/8/17

☒ Employee can return to work as of 2/16/18 **without restrictions.**

☐ Employee can return to work as of _____ **with the restrictions** identified below which are expected to last through _____. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.

☐ Employee is **unable to return to work** as of _____ and is expected to be off of work *through:*
☐ _____(date) ☐ until next appointment (listed below) and will be assessed then.
☐ until surgery. (awaiting W/C approval). ☐ until diagnostic testing (listed below) is complete. (awaiting W/C approval)

Posture/Motion Restrictions (if any):

☐ Standing	Not to exceed ____ hrs/day		☐ Walking	Not to exceed ____ hrs/day	
☐ Sitting	Not to exceed ____ hrs/day		☐ Climbing	Not to exceed ____ hrs/day	
☐ Kneeling/Squatting	Not to exceed ____ hrs/day		☐ Grasping	Not to exceed ____ hrs/day	
☐ Bending/Stooping	Not to exceed ____ hrs/day		☐ Squeezing	Not to exceed ____ hrs/day	
☐ Twisting	Not to exceed ____ hrs/day		☐ Reaching	Not to exceed ____ hrs/day	
☐ Pushing/Pulling	Not to exceed ____ hrs/day		☐ Overhead	Not to exceed ____ hrs/day	
☐ Lifting/Carrying	Not to exceed ____ hrs/day		☐ Keyboarding	Not to exceed ____ hrs/day	

No Work Involving:

Hand/Wrist/Arm	☐ R	☐ L
Leg	☐ R	☐ L
Foot/Ankle	☐ R	☐ L
Neck	☐	
Back	☐	

Lift/Carry/Push/Pull Restrictions

☐ Not to exceed ____ lbs	☐ R	☐ L
☐ No lifting/carrying	☐ R	☐ L
☐ No pushing/pulling	☐ R	☐ L
☐ No pinching	☐ R	☐ L
☐ No grasping/squeezing	☐ R	☐ L

Climbing Restrictions

☐ No ladder	☐ R	☐ L
☐ No stairs	☐ R	☐ L
☐ No ramp	☐ R	☐ L

Misc. Restrictions

- ☐ Wear splint/brace/sling/cast at work
- ☐ Sitting only
- ☐ Must use crutches
- ☐ Walking/Standing as tolerated
- ☐ No driving
- ☐ No operating heavy equipment/moving machine
- ☐ No overhead work

Other Restrictions (if any): _____

Expected Follow-up Services Include:

☒ Next Appointment Date: 3/16/18 Time: 8:15AM at Gurnee Office

☐ Diagnostic Studies Requested: _____

☐ Surgery Recommended: _____

☐ Rehab (PT/OT) Recommended: _____ x per week for _____ weeks starting _____

☐ Referral to: _____

☐ NONE. This is the last scheduled visit for this problem. At this time no further medical care is anticipated.

Note Completed By: Adriana Cortez, CCMA

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