

 S.R.C. - Pipestone, MN U.S.A.		<h2>Suzlon Accident Report</h2>
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Team Member: Javier Valentin Perez Taken to Hospital or Clinic? Y N
 Date of Occurrence: 1-19-08 Is This a Near Miss? Y N
 Time of Occurrence: 9am
 Date Reported: 4-2-08 Team Leader: Joe
 Department: Finishing Day shift Night shift

Location of where accident occurred (be specific)
Finishing department at Suzlon

Description of accident / injury
Working with the resin some how spilt into ^{his left} eye and on his right arm.

Witnesses names

Corrective action (If needs further investigation use form F:ST:02)
Face shield needs to be worn, disciplinary action will be taken if one is not worn when working with resin
 Employee Feedback

<u>JAVIER PEREZ VALENTIN.</u>	_____ Date
Team Member Signature	<u>4-2-08</u> Date
 Team Leader Signature	_____ Date
_____ Safety Officer Signature	_____ Date

Team Leader: Perform Accident Investigation, Implement Corrective Action, and submit completed form to the Safety and Environmental Officer before the end of your shift

RECEIVED
 APR 02 2008

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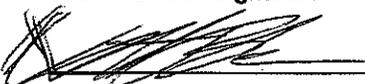
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JAVIER PEREZ VALENTIN.
 Team Member Signature _____ Date _____

 Team Leader Signature _____ Date 4-2-08

Safety Officer Signature _____ Date _____
Team Leader: Perform Accident Investigation, Implement Corrective Action, and submit completed form to the Safety and Environmental Officer before the end of your shift

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Submit This Form

Minnesota Department of Labor and Industry
 Workers' Compensation Division
 443 Lafayette Road North
 St. Paul, MN 55155-4305
 (651) 284-5030

First Report of Injury

See Instructions on Reverse Side.
 Please PRINT or TYPE your responses.
 Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY # 584-89-0317		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 1/19/2008		4. Time of injury 09:00	<input checked="" type="checkbox"/> am <input type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Perez Valentin Javier		7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried
9. Home address 132 17TH ST. City: Heron Lake State: MN Zip Code: 56137		10. Home phone # (507) 370-7140	11. Date of birth 6/2/1980
12. Occupation Production Worker		13. Regular department Finishing	
14. Date hired 11/26/2007		15. Average weekly wage \$400.00	
16. Rate per hour \$10.00		17. Hours per day 8	
18. Days per week 6		19. Employment Status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Seasonal <input type="checkbox"/> Part time <input type="checkbox"/> Volunteer	
20. Weekly value of: Meals: \$0.00 Lodging: \$0.00		21. Apprentice <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
22. Tell us how the injury occurred and what the employee was doing before the incident (give details). Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry." Working with the resin and some how it split into his left eye and onto his right arm.			
23. What was the injury or illness (include the part(s) of body)? Left Eye, Right Arm		24. What tools, equipment, machines, objects, or substances were involved? Resin	
25. Did injury occur on employer's premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Date of first day of any lost time	
If no, indicate name and address of place of occurrence		27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No lost time on DOI	
28. Date employer notified of injury 4/2/2008		29. Date employer notified of lost time	
30. Return to work date 1/19/2008		31. Date of death	
32. TREATING PHYSICIAN (name, address, and phone) 507-825-5700		33. HOSPITAL/CLINIC (name and address) (if any) Pipstone Medical Group 920 4th Ave SW Pipstone MN 56164	
34. Emergency Room Visit <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		35. Overnight in-patient <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
36. EMPLOYER Legal name CORPORATE MANAGEMENT GROUP INC 188602		37. EMPLOYER DBA name (if different)	
38. Mailing address 12000 N. WASHINGTON ST. #290 City: THORNTON State: CO Zip Code: 80241		39. Employer FEIN	
40. Unemployment ID # 0036373110		41. Employer's contact name and phone # Amanda Carnahan (303) 920-1425	
42. Physical address (if different)		43. Witness (name and phone)	
44. NAICS code		45. Date form completed 04/02/2008	
46. INSURER name MINNESOTA ASSIGNED RISK PLAN		51. CLAIMS ADMIN COMPANY (CA) name (check one) Berkley Risk Administrators Company, LLC Insurer TPA	
47. Insured legal name		52. CA Address 222 South Ninth Street	
48. Policy # or self-insured certificate #		City: Minneapolis State: MN Zip Code: 55402	
49. Insurer FEIN		53. CA FEIN 41-1887666	
50. Date insurer received notice 04/02/2008		54. Claim # 04 - 188602 -	

SUPERVISOR'S REPORT OF ACCIDENT

(PLEASE READ AND FOLLOW INSTRUCTIONS ON BACK)

EVERY ACCIDENT SHOULD BE INVESTIGATED AND THE CAUSES CORRECTED SO THAT MORE ACCIDENTS WILL NOT OCCUR. DO NOT OVERLOOK THE SO-CALLED "UNIMPORTANT" CASES, BECAUSE, EXCEPT FOR "CHANCE" THEY COULD ALSO HAVE BEEN SERIOUS. IT IS ONLY BY THOROUGH INVESTIGATION THAT MANY OF THE REAL CAUSES CAN BE DETERMINED AND CORRECTED.

NAME OF EMPLOYEE Javier Perez Valentin COMPANY CORPORATE MANAGEM DEPT. Finishing
DATE OF ACCIDENT 1/19/2008 TIME 9:00 AM DID EMPLOYEE LOSE TIME FROM WORK? YES NO
HOURS LOST ON DATE OF ACCIDENT N/A HAS EMPLOYEE RETURNED TO WORK? YES NO
JOB TITLE Production Worker SERVICE WITH THE COMPANY 6 mo YEARS IN PRESENT JOB 6 mo

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING:

CHECK "YES" OR "NO"

- | | | |
|--|---|--|
| 1. WAS INJURED PERSON PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS? | YES <input checked="" type="checkbox"/> | NO <input type="checkbox"/> |
| 2. DID INJURED PERSON VIOLATE ANY INSTRUCTIONS? | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> |
| 3. WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE) | YES <input checked="" type="checkbox"/> | NO <input type="checkbox"/> |
| 4. DID POOR HOUSEKEEPING CONTRIBUTE TO INJURY? | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> |
| 5. DID HORSEPLAY CAUSE THE INJURY? | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> |
| 6. WAS IT CAUSED BY SOMETHING WHICH NEEDED REPAIRS? | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> |
| 7. SHOULD A GUARD BE PROVIDED? | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> |
| 8. DID ANY BODILY DEFECT CONTRIBUTE TO INJURY? | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> |
| 9. WAS IT CAUSED BY AN UNSAFE ACT? | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> |
| 10. DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY? | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> |

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.) Working with the resin and some how it split into his left eye and onto his right arm.

WITNESSES' NAMES _____

UNSAFE ACTS. (WHAT DID THE EMPLOYEE OR ANOTHER PERSON DO INCORRECTLY?) _____

N/A

UNSAFE CONDITIONS. (WHAT UNGUARDED OR UNSAFE CONDITION OF MACHINERY, EQUIPMENT, BUILDING OR PREMISES WAS INVOLVED?) _____

N/A

ACTIONS TAKEN. (WHAT DID YOU DO TO CORRECT THE CONDITIONS WHICH CAUSED THIS INJURY?) _____

Faceshield needs to be worn, disciplinary actions will be taken if one is not worn when working with resin.

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?) _____

MEDICAL CARE. DID EMPLOYEE GO TO DOCTOR OR HOSPITAL? YES NO IF YES, COMPLETE THE FOLLOWING

NAME OF DOCTOR OR HOSPITAL Pipestone Medical Group DATE OF INITIAL VISIT 01/19/2008
ADDRESS 920 4th Ave SW, Pipestone, MN 56164 TELEPHONE NUMBER 507-825-5700

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES NO

REASONS WHY It happened at work.

REPORT SUBMITTED BY Ashley Postma DATE 04/02/2008
Administrative Assistant