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

Suzlon Accident Report

Team Member: Jessica Potts

Taken to Hospital or Clinic? Y ✓ N ___ @ 11:00 am

Date of Occurrence: 3-26-08

Is This a Near Miss? Y ___ N ✓ Direct Hit

Time of Occurrence: 10:00 am

Date Reported: 3-26-08

Team Leader: Tanya Fongemie

Department: Prefab

Day shift ✓ Night shift ___

Location of where accident occurred (*be specific*)

Red Line Girders in Prefab

Description of accident / injury

Was on floor changing hoses. She has now broke out in a rash and stinging.

Witnesses names

Tosha witness same reaction in class last week.

Corrective action (If needs further investigation use form F:ST:02)

Employee Feedback

Jessica K. Potts — Team Member Signature — 3-26-08 — Date

Read 3-26-08

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
MAR 31 2008
BY:

Health Care Provider Report

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

HC01

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
		10-30-73
EMPLOYEE Jessica Potts	EMPLOYER Suzlon	
INSURER/SELF-INSURER/TPA	INSURER CLAIM NUMBER	
INSURER ADDRESS		
CITY	STATE ZIP CODE	

REQUESTER must specify all items to be completed by health care provider. ☐ Items: _____ ☐ MMI (#9) ☐ PPD (#10)

HEALTH CARE PROVIDER TO COMPLETE ITEMS REQUESTED ABOVE

1. Date of first examination for this injury by this office: 3-26-08 (date)
2. Diagnosis (include all ICD-9-CM codes):
   Allergic Dermatitis
3. History of injury or disease given by employee:
   Skin sensitive to dusts at work
4. In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? ☐ No ☒ Yes
5. Is there evidence of pre-existing or other conditions that affect this disability? ☒ No ☐ Yes If yes, describe:
6. Is further treatment of this injury or referral to another doctor planned? ☒ No ☐ Yes If yes, describe:
7. Has surgery been performed? ☒ No ☐ Yes If yes, date and describe: (date)
8. Attach the most recent Report of Work Ability. Date of report: 3/26/08 (date)
9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) ☒ No ☐ Yes Date reached:
10. Has the employee sustained any permanent partial disability from the injury? ☒ No ☐ Yes ☐ Too early to determine
    The permanent partial disability is % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

NAME (Type or Print)	SIGNATURE	DEGREE
HEIDI M. THORESON, PA PIPESTONE MEDICAL GROUP ADDRESS 920 4TH AVE SW, PIPESTONE, MN 56164 507-825-5700 FAX 507-825-5895 DEA- MT1547833 MN LISC-10239 CITY UPIN Q75758 NPI - 1689722027	Heidi Thoreson	PA-C
	STATE	LICENSE #/REGISTRATION #
	AREA CODE / TELEPHONE #	DATE SIGNED 3/26/08

MN HC01 (7/01).

Report of Work Ability

See Instructions on Reverse Side

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

RW01

DO NOT USE THIS SPACE

This form must be provided to the employee.
(Minn. Rules 5221.0410, subp. 6)

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

SOCIAL SECURITY NUMBER	DATE OF INJURY
EMPLOYEE Jessica Potts	Date of Birth 10-30-73
EMPLOYER Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 3-26-08 (date)

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

1. [X] Employee is able to work without restrictions as of 3/26/08 (date)

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

The restrictions are:

3. [ ] Employee is unable to work at all, from (date) to (date)

The next scheduled visit is: [X] as needed OR (date)

NAME (T	SIGNATURE Heidi Thoreson	DEGREE PA-C
ADDRES HEIDI M. THORESON, PA PIPESTONE FAMILY CLINIC 920 4TH AVE SW, PIPESTONE, MN 56164 507-825-5700 FAX 507-825-5895 DEA- MT1547833 MN LISC-10239 UPIN Q75758 NPI - 1689722027	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE / TELEPHONE #	DATE SIGNED 3-26-08

MN RW01 (7/01)

CMG SUZLON ROTOR 0100
1711 S US HWY 75
PIPESTONE MN 56164

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA ☐ PICA ☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 456358159

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): POTTS JESSICA K

3. PATIENT'S BIRTH DATE MM DD YY: 10 30 1973 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): POTTS JESSICA K

5. PATIENT'S ADDRESS (No., Street): 309 W MAIN ST

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☒

7. INSURED'S ADDRESS (No., Street): 309 W MAIN ST

CITY: PIPESTONE STATE: MN

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: PIPESTONE STATE: MN

ZIP CODE: 56164 TELEPHONE (Include Area Code): (507) 825 0094

ZIP CODE: 56164 TELEPHONE (Include Area Code): (507) 825 0094

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: CMG SUZLON ROTOR

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: BERKLEY RISK MANAGEMENT

d. INSURANCE PLAN NAME OR PROGRAM NAME: NO OTHER COVERAGE

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE 032808

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: GREG A COOPER MD

17a. 1G D80008

17b. NPI 1730179870

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 692.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 26 08	03 26 08	11		99213		1	81 00	1		NPI	1689722027
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒: 411392082

26. PATIENT'S ACCOUNT NO.: 74124331

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE $ 81 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 81 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
079738
HEIDI M THORESON PA
SIGNED 032808 DATE

32. SERVICE FACILITY LOCATION INFORMATION
PIPESTONE FAMILY CLINIC
920 4TH AVE SW
PIPESTONE MN 56164-1455
a. 1073576904

33. BILLING PROVIDER INFO & PH # (507) 825 5700
PIPESTONE FAMILY CLINIC
920 4TH AVENUE SW
PIPESTONE MN 56164
a. 1689722027

790-0116 (08-05) (OCR) IPT.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

WC101937