



# Suzlon Accident Report

ESSG

Team Member: Aileen Howard

Taken to Hospital or Clinic? Y  N

Date of Occurrence: 1/7/08

Is This a Near Miss? Y  N

Time of Occurrence: 7pm

Date Reported: 1/7/08

Team Leader: Sarah Mallak

Department: Mat Prep

Day shift  Night shift

**Location of where accident occurred (be specific)**

Mat Prep

**Description of accident / injury**

She was transferred from finishing to Mat Prep, but her rash continued to get worse.

**Witnesses names**

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

Went to hospital. Dr gave her perscriptions with no work limitations so she will return tomorrow.

**Employee Feedback**

~~Signature~~  
Team Member Signature

\_\_\_\_\_  
Date

Brenda Zined  
Team Leader Signature

1/7/08  
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  
1/10/08  
ems*



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

# Referral for Medical Treatment Report to Employer

Employee Name: Allen Howard Date of Injury: 01/07/08

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Health Care Provider who completes this form to release any information to The Suzlon Rotor Corporation which substantiates, clarifies, or elaborates on my fitness for duty.

Allen Howard  
Employee Signature Date 01/07/08

Medical Provider Lastine Date / Time of Appt: \_\_\_\_\_

ALL WORKERS' COMPENSATION MEDICAL EXPENSES must include the patient name, date of service, and Medical Provider's "Progress Notes" for treatment. Social Security Number is recommended. Mail all claims for payment directly to:

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

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

Diagnosis: Contact Dermatitis \_\_\_\_\_ Non-work related

Treatment Plan: \_\_\_\_\_  
\_\_\_\_\_ Undetermined  
 Work related

RETURN TO WORK:  With No Limitations Date: 1-7-08  
(Suzlon rotor Corp. has an active return-to-work program. Most temporary restrictions can be accommodated. Please call 507-562-6700 if you have any questions regarding light duty jobs.)

TOTALLY DISABLED: (Dates) From: \_\_\_\_\_ To: \_\_\_\_\_

RESTRICTED WORK: Duration of Limitations: \_\_\_\_\_ Days/Weeks

~~Restricted Work Hours: May Work \_\_\_\_\_ hours per day \_\_\_\_\_ hours per week.  
Restricted Lifting: Maximum lift: \_\_\_\_\_ 10lbs \_\_\_\_\_ 20lbs \_\_\_\_\_ 30lbs \_\_\_\_\_ 40lbs \_\_\_\_\_ 50lbs  
Weight limit for repetitive lifting or carrying: (more frequent than 2 times per hour)  
\_\_\_\_\_ 0-5lbs \_\_\_\_\_ 5-10lbs \_\_\_\_\_ 10-20lbs \_\_\_\_\_ 20-30lbs \_\_\_\_\_ 30-40  
Restricted bending: (Limit in degrees) \_\_\_\_\_ Bending frequency (# of times per hour): \_\_\_\_\_  
Restricted use of hand: \_\_\_\_\_ Right \_\_\_\_\_ Left No Use or \_\_\_\_\_ Limited repetitive grasping, gripping  
Standing/Sitting: Standing (hours per day) \_\_\_\_\_ Sitting (hours per day) \_\_\_\_\_  
Other: \_\_\_\_\_~~

Next Appt. Date / Time: \_\_\_\_\_ Provider's Comments: \_\_\_\_\_

Medical Provider Signature: M Lastine Date: 1-7-08