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

Suzlon Injury Report

Team Member: Barry Alderson

Date of Occurrence: 6/12/08

Time of Occurrence: unk

Department: Finishing

Team Leader: Joel Swenson

Date Reported: 6/16/08

If taken to Doctor, fill out this section

Date of Treatment: 6-16-2008

Time of Treatment: 1:20

Doctor: Kovacik

Drug Test Performed: (Yes) No

Drug test date & time:

Location of where accident occurred (*be specific*)

Finishing department - painting/sanding blades

Description of accident / injury

Red watery eyes, rash on lower arms. Skin is itchy.

Witnesses names

Joel Swenson

Corrective action (*include: task, equipment, environmental, and management factors*) – If needs further investigation use form F:ST:02

Employee Feedback

Barry Alderson — Team Member Signature — 6-16-08 — Date

Joel Swenson — Manager Signature — 16 Jun 08 — Date

Thomas Funk — Human Resources Signature — 6-16-2008 — Date

RECEIVED
JUN 16 2008
BY:

Report of Work Ability

See Instructions on Reverse Side

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

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

RW01

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER	DATE OF INJURY
469173775	6-12-08
EMPLOYEE Barry Alderson	Date of Birth 11-13-88
EMPLOYER Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 6-16-08 (date)

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

1. [X] Employee is able to work without restrictions as of 6/16/08 (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: [ ] as needed OR (date)

NAME (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER ADDRESS 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 CITY UPIN D25406 NPI 1699738559	B. Kocourek	
	STATE	LICENSE #/REGISTRATION #
	AREA CODE / TELEPHONE #	DATE SIGNED 6/16/08

MN RW01 (7/01)

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
469 17 3775	6-12-08	11-13-88
EMPLOYEE: Barry Alderson	EMPLOYER: Suzlon Rotor	
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: 6/16/08 (date)

2. Diagnosis (include all ICD-9-CM codes):
allergic dermatitis - fiberglass allergy

3. History of injury or disease given by employee:
gradual worsening back & sinusitis blades

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: 6/16/08 (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
BRUCE W KOCOUREK, DO	B Kocourek	
ADDRESS: PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	STATE	LICENSE #/REGISTRATION #
CITY: UPIN D25406 NPI 1699738559	AREA CODE / TELEPHONE #	DATE SIGNED: 6/16/08

MN HC01 (7/01).

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

Referral for Medical Treatment Report to Employer

Employee Name: Barry Atkinson **Date of Injury:** 6-12-2008

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.

_______________ Employee Signature _______________ Date

Medical Provider Dr. Kovarik **Date / Time of Appt:** 6-16-2008 1:20

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: fiberglass allergy c dermatitis

____ **Non-work related**

____ **Undetermined**

Treatment Plan: Medrol dosepak, Zyrtec

X **Work related**

RETURN TO WORK: X **With No Limitations** **Date:** 6/16/08

(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:** ________

maximal protection of skin

Medical Provider Signature: [signature] **Date:** 6/16/08