ACCIDENT REPORTING PROCEDURES

Employees are required to report all job related injuries to your Manager or Human Resources immediately of the occurrence. *The Manager with the Employee will conduct an accident investigation.* Human Resources or the Manager may provide first aid treatment. If your injury needs to be seen by a medical provider:

1. **A medical referral form must be picked up from the Human Resources or the Manager to take along to the medical provider before each medical visit (except for emergencies).**

2. **The completed medical referral form must be returned immediately to the Human Resources after the medical providers' visit along with the date and time of next appointment.**

3. Any change in attending medical providers must be approved by the Insurance Carrier or coordinated with the Human Resources.

If your job assignment aggravates an already existing physical condition, notify your immediate Manager and Human Resources. A review of your job assignment will be made.

5. **Return to Work Assignments** are used to provide short-term work that accommodates restrictions of Employees as early as possible after an injury. Our goal is to maintain regular contact with the Employee, provide support, maintain a safe work environment during the convenient period, avoid pitfalls of disability and keep the person gainfully employed within their present medical restrictions until returned to their regular job. Medical placement in to a temporary return to work assignment is accomplished by written approval from a physician with the assistance from an Occupational Specialist and CMG Management.

Employees will be retained within their job classifications whenever possible. If the employee remains on restricted duty regular progress meetings will be scheduled. If the Employee cannot return to their regular job within a reasonable time period, (i.e. sixty to ninety calendar days) the Employee may be considered for alternate placement within CMG or Outplacement Rehabilitation.

Regular communication must be maintained with your Manager and Human Resources after any work related injury has occurred. *Future medical providers' visits or absences should be coordinated through Human Resources for accurate reporting of Employees medical condition.* Failure to comply with this policy may result in disciplinary action or cause a delay in Insurance benefits.

Clocking and pay procedure: Employee's if leaving the building will clock out and will not be paid by CMG while attending appointments. All lost time hours of pay will be paid by submitting by the employee to the insurance carrier and reimburse at 66 2/3% of their straight time wages (less applicable taxes) in accordance with State Worker's Compensation laws.

I have read received a copy and will comply with these procedures or be subject to disciplinary action up to and including termination of employment.

Employee Signature _____ Date: 6-25-08

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

Suzlon Accident Report

Team Member: Casey Olson

Taken to Hospital or Clinic? Y ✓ N ___

Date of Occurrence: 6/24/08

Is This a Near Miss? Y ___ N ✓

Time of Occurrence: 10:00 Am

Date Reported: 6/24/08

Team Leader: Eddie Torres

Department: Mould Blue Line

Day shift ✓ Night shift ___

Location of where accident occurred (*be specific*)

Under Blue Line mould

Description of accident / injury

Was changing hoses under mould, holding hose with left hand and cutting with right hand, hand slipped with knife cutting left arm.

Witnesses names

none

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

Using proper tool to cut hose with. Each mould team Lead should have a hose cutter.

Employee Feedback

Casey Olson — Team Member Signature — 6-25-08 — Date

Corrina Leach — Team Leader Signature — 6/24/08 — Date

Thomas Funk — Safety Officer Signature — 6-24-2008 — 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*

Report of Work Ability

See Instructions on Reverse Side

RW01

DO NOT USE THIS SPACE

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)

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
468088163	6-24-08
EMPLOYEE: Casey Olson	Date of Birth: 5-16-86
EMPLOYER: CMH - Sinclon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 6-24-08 (date)

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

1. [X] Employee is able to work without restrictions as of 6/24/08 (date)

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

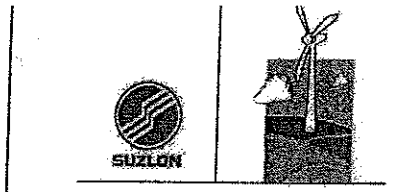
The restrictions are:

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
ADDRESS: DAVID A BALT, DO PIPESTONE FAMILY CLINIC 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 ext4770 FAX 507-825-4767 DEA-BB2194075 MN LISC-37593 UPIN E51053 NPI - 1457315038	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE / TELEPHONE #	DATE SIGNED

MN RW01 (7/01)



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

Referral for Medical Treatment Report to Employer

Employee Name: Casey Olson **Date of Injury:** 6-24-08

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.

Employee Signature _____ Date _____

Medical Provider Balt **Date / Time of Appt:** 6-24-08 10:30

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~~ Berkley
~~PO Box 8016~~
~~Wausau, WI 54402~~ Minneapolis, MN

~~1-877-870-1542~~

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

Diagnosis: _____ _____ **Non-work related**

_____ _____ **Undetermined**

Treatment Plan: _____ _____ **Work related**

RETURN TO WORK: _____ **With No Limitations** **Date:** _____

(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: _____ **Date:** _____

PATIENT REGISTRATION FORM

Form 880

Account # WC152812
Hosp #

PIPESTONE FAMILY CLINIC
507 825 5700

Date: June 24 2008

PATIENT

Name OLSON CASEY

Address 410 MAIN STREET

RUTHTON MN 56170

Date of Birth: 5/16/1986 Sex: M
Marital Status:
Soc Sec Number: 468088163
DPOA ON FILE?
Home: 507 658 3992
PTWK PHONE:
Cell Phone: 5075302945

BILL TO

Name OLSON CASEY
Address 410 MAIN ST

RUTHTON MN 56170

Work Phone
507 562 6700 Ext 0

Employer 0

INSURANCE

PRIMARY INSURANCE CARRIER
Subscriber Information

Name OLSON CASEY
SSN 468088163 DOB 5/16/86 SEX M
Relation to Insured:
34-EMPLOYEE

Insurance Co 105 Plan 457
BERKLEY RISK MANAGEMENT
Address PO BOX 59143

MINNEAPOLIS MN 55459
Phone 800 449 7707

Effective Date: 0/00/00
ID#:
468088163

Employer 1833
CMG SUZLON ROTOR
Address 1711 S US HWY 75

PIPESTONE MN 56164

SECONDARY INSURANCE CARRIER
Subscriber Information

Name
SSN DOB SEX
Relation to Insured:

Insurance Co Plan

Address

Phone

Effective Date:
ID#:

Employer

Address

Date Registered: 6/24/08

Date Reviewed: 3/28/08

Alt Comm Authorization: YES

HIPAA PRIVACY NOTICE
YES

Pipestone County Medical Center

Carey
has an appointment

☐ Mon. ☒ Tues. ☐ Wed. ☐ Thurs. ☐ Fri.

Date 7-1 At 9:40 (A.M.) P.M.

☒ Dr. David Balt
☐ Dr. Larry Christensen
☐ Dr. Greg Cooper
☐ Dr. Theodore Devaraj
☐ Dr. Bruce Kocourek
☐ Dr. Mike Lastine
☐ Dr. Matthew Viel
☐ Cindy Sash PA-C
☐ Heidi Thoreson PA-C
☐ Melissa Scotting CNP

IF UNABLE TO KEEP APPOINTMENT, PLEASE GIVE 24 HOUR NOTICE
Please come 15 minutes before your appointment to check in

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.

FR01

DO NOT USE THIS SPACE

188(

1. EMPLOYEE SOCIAL SECURITY # 468-08-8163	2. OSHA Case #						
3. DATE OF CLAIMED INJURY 6/24/2008	4. Time of injury 10:00 ☑ am ☐ pm	5. Time employee began work on date of injury 07:00 ☑ am ☐ pm					
6. EMPLOYEE Name (last, first, middle) Olson Casey	7. Gender ☑ M ☐ F	8. Marital Status ☐ Married ☑ Unmarried					
9. Home address 410 Main Street	10. Home phone # (507) 658-3992	11. Date of birth 5/16/1986					
City Ruthon	State MN	Zip Code 56170	12. Occupation Production Worker	13. Regular department Mould	14. Date hired 5/12/2008		
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 ☑ Full time ☐ Part time ☐ Seasonal ☐ Volunteer			
20. Weekly value of: Meals $0.00	Lodging $0.00	2nd income $0.00	21. Apprentice ☐ Yes ☑ 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."*

Casey was changing hoses under the mould, holding hose with left hand and cutting with right hand, and hand slipped with knife and cut his left arm.

23. What was the injury or illness (include the part(s) of body)? *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist* left arm	24. What tools, equipment, machines, objects, or substances were involved? *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard* knife, hose, mould

25. Did injury occur on employer's premises? ☑ Yes ☐ No If no, indicate name and address of place of occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☑ No lost time on DOI
	28. Date employer notified of injury 6/24/2008	29. Date employer notified of lost time
	30. Return to work date 6/24/2008	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone) 507-825-5700	33. HOSPITAL/CLINIC (name and address) (if any) Pipestone Medical Group 920 4th Ave SW Pipestone MN 56164	34. Emergency Room Visit ☑ Yes ☐ No 35. Overnight in-patient ☐ Yes ☑ No

36. **EMPLOYER** Legal name CORPORATE MANAGEMENT GROUP INC 188602		37. EMPLOYER DBA name (if different)	
38. **Mailing** address 12000 N. WASHINGTON ST. #290		39. Employer FEIN	40. Unemployment ID # 0036373110
City THORNTON	State CO	Zip Code 80241	41. Employer's contact name and phone # Amanda Carnahan (303) 920-1425
42. **Physical** address (if different)			43. Witness (name and phone)
City	State	Zip Code	44. NAICS code / 45. Date form completed 06/24/2008

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	50. Date insurer received notice 06/24/2008	53. CA FEIN 41-1887666	54. Claim # 04 - 188602 -

MN FR01 (05/03) Copies to: Insurer, Employer, Employee, and Workers' Compensation Division (if no insurer)

BRAC 2510 (7/05)

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 Casey Olson COMPANY CORPORATE MANAGEM DEPT. Mould

DATE OF ACCIDENT 6/24/2008 TIME 10:00 AM DID EMPLOYEE LOSE TIME FROM WORK? YES ☐ NO ☑

HOURS LOST ON DATE OF ACCIDENT 0 HAS EMPLOYEE RETURNED TO WORK? YES ☑ NO ☐

JOB TITLE Production Worker SERVICE WITH THE COMPANY 3 mo YEARS IN PRESENT JOB 3 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 ☑	NO ☐
2.	DID INJURED PERSON VIOLATE ANY INSTRUCTIONS?	NO ☑	YES ☐
3.	WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE)	YES ☑	NO ☐
4.	DID POOR HOUSEKEEPING CONTRIBUTE TO INJURY?	NO ☑	YES ☐
5.	DID HORSEPLAY CAUSE THE INJURY?	NO ☑	YES ☐
6.	WAS IT CAUSED BY SOMETHING WHICH NEEDED REPAIRS?	NO ☑	YES ☐
7.	SHOULD A GUARD BE PROVIDED?	NO ☑	YES ☐
8.	DID ANY BODILY DEFECT CONTRIBUTE TO INJURY?	NO ☑	YES ☐
9.	WAS IT CAUSED BY AN UNSAFE ACT?	NO ☑	YES ☐
10.	DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY?	YES ☑	NO ☐

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.) Casey was changing hoses under the mould, holding hose with left hand and cutting with right hand, and hand slipped with knife and cut his left 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?)

Using proper tool to cut hose. Each mould team lead should have a hose cutter.

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

N/A

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 06/24/2008

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 If happended while using the tools and materials of the job.

REPORT SUBMITTED BY Ashley Postma DATE 06/24/2008

Administrative Assistant

BRAC 2520 (10/99)