



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

Suzlon Injury Report

Team Member: Chad Peters

Date of Occurrence: 4-April-08

Time of Occurrence: _____

Department: Saw/Drill

Team Leader: Jerrill Murray

Date Reported: 8-April-08 ?

If taken to Doctor, fill out this section

Date of Treatment: 4-4-2008
4-6-2008

Time of Treatment: _____

Doctor: Sanford Medical Clinic

Drug Test Performed: Yes No

Drug test date & time: 4-11-2008

Location of where accident occurred (be specific)

Saw/Drill - East Machine -

Description of accident / injury

Standing in foot area of blade, trimming excess material off
Foot area.

Witnesses names

None

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

Use ladder to trim Root From outside of blade

Dept. Not behind in production, need to slow down.

Employee Feedback

Stand in foot end to cut excess stuff off to spend no process

Team Member Signature

10/April/08
Date

Manager Signature

10-April-08
Date

Human Resources Signature

Date

RECEIVED
APR 11 2008

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 # 483-13-5277		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 4/8/2008		4. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm	5. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Peters Chad		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 417 5th Street SW.		10. Home phone # (507) 825-2477	11. Date of birth 2/17/1973
City Pipestone	State MN	Zip Code 56164	12. Occupation Production Worker
13. Regular department Finishing		14. Date hired 3/3/2008	
15. Average weekly wage \$424.00	16. Rate per hour \$10.60	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	2 nd income \$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." Standing in root area of the blade, trimming excess material off the root area.			
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 Lower back		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard blade, saw and drill	
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no, indicate name and address of place of occurrence Employee isn't sure when and where		26. Date of first day of any lost time 4/10/2008	27. Employer paid for lost time on day of injury (DOI) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI
28. Date employer notified of injury 4/10/2008		29. Date employer notified of lost time 4/10/2008	
30. Return to work date		31. Date of death	
32. TREATING PHYSICIAN (name, address, and phone) Dr. Huffman 900 E 54th Street Suite 200 Sioux Falls SD 57104		33. HOSPITAL/CLINIC (name and address) (if any) Sanford Health 900 E 54th Street Suite 200 Sioux Falls SD 57104	
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		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 04/11/2008	
46. INSURER name MINNESOTA ASSIGNED RISK PLAN		51. CLAIMS ADMIN COMPANY (CA) name (check one) Insurer Berkley Risk Administrators Company, LLC 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 04/11/2008	53. CA FEIN 41-1887666	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 Chad Peters COMPANY CORPORATE MANAGEM DEPT. Finishing
DATE OF ACCIDENT 4/8/2008 TIME _____ DID EMPLOYEE LOSE TIME FROM WORK? YES NO
HOURS LOST ON DATE OF ACCIDENT 16 hours 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 <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.) Standing in root area of the blade, trimming excess material off the root area.

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?) _____

Educate employee to use a labber to trim root from outside of blade. Also that the department was not behind in production, need to slow down.

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 Dr. Huffman DATE OF INITIAL VISIT 04/10/2008

ADDRESS 900 E 54th Street Suite 200, Sioux Falls, SD 57104 TELEPHONE NUMBER _____

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

REASONS WHY No because employee is not sure if it happened while at work.

REPORT SUBMITTED BY Ashley Postma

DATE 04/11/2008

Administrative Assistant