



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

Suzlon Accident Report

Team Member: Dawood christopher taken to Hospital or Clinic? Y N

Date of Occurrence: 5-2-08 Is This a Near Miss? Y N

Time of Occurrence: 7:20 pm

Date Reported: 5-2-08 Team Leader: Ochogi Opiew

Department: Nose cone Day shift Night shift

Location of where accident occurred (be specific)

It @hppened at nose cone working area.

Description of accident / injury

He was cutting the sleeves and fall on his right thumb and cut.

Witnesses names

No one

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

taken to hospital and got 2 stitches

Employee Feedback

He is able to work

Team Member Signature

Date

Ochogi Opiew
Team Leader Signature

5-2-08
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
MAY 06 2008



Medical Referral to Employer

Employee Name: Dawood, Christopher Date of Injury: 5/2/08

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.

Dawood, Christopher
Employee Signature

5/2/08
Date

Medical Provider _____ 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:

**Berkley Risk
PO BOX 59143
Minneapolis, MN 55459-0413
(612)766-3000**

Incomplete billings or those mailed directly to Corporate Management Group may result in slow payment processes.

Diagnosis: Ulnar deviation R hand

___ Non-work related

___ Undetermined

Treatment Plan: Indus

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: 10-14 d 1 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: _____

*Keep
wound clean
dry & covered,
& wear glove.*

Medical Provider Signature: [Signature]

Date: 5.2.08



FITNESS FOR DUTY

Employees who are absent due to illness or injury (either work-related or non-occupational) may be required to have their physician or other qualified health provider complete a Fitness for Duty Certification before returning to work. The completed form should be returned to Human Resources will make a determination as to his/her ability to return to work. No employee will be allowed to return to work without a satisfactory Fitness for Duty Certification on file.

Employee Name: Dawood, Christopher Date: 5/2/08

Is employee able to perform the functions of his/her position? Yes No

Any restrictions? Yes No If yes, please describe restriction(s) and duration below:

RETURN TO WORK: With No Limitations Date: _____

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_____ 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: 10-14 d. Provider's Comments: _____

Employee Signature: _____

Physician or Practitioner Signature: _____

Type of Practice: (Field of Specialization) _____

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 # 667-09-7924		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 5/2/2008		4. Time of injury 07:20 <input checked="" type="checkbox"/> am <input checked="" type="checkbox"/> pm	5. Time employee began work on date of injury 03:45 <input type="checkbox"/> am <input checked="" type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Dawood Christopher		7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Unmarried
9. Home address 1009 3rd Ave Apt 207		10. Home phone # (507) 521-0845	11. Date of birth 1/1/1968
City Worthington	State MN	Zip Code 56187	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." Christopher was cutting the sleeves and fell on his right thumb and cut it.			
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 right thumb		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. Sleeves	
25. Did injury occur on employer's premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> No lost time on DOI
		28. Date employer notified of injury 5/2/2008	29. Date employer notified of lost time
		30. Return to work date 5/2/2008	31. Date of death
32. TREATING PHYSICIAN (name, address, and phone) 507-825-5700		33. HOSPITAL/CLINIC (name and address) (if any) Pipstone Medical Group 920 4th Ave SW Pipstone MN 56164	
		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 05/06/2008	
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 05/06/2008	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 Christopher Dawood COMPANY CORPORATE MANAGEM DEPT. Finishing
DATE OF ACCIDENT 5/2/2008 TIME 7:20 PM 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 <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 checked="" type="checkbox"/> | NO <input type="checkbox"/> |

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.) Christopher was cutting the sleeves and fell on his right thumb and cut it.

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?) _____

Took to the hospital and received two stiches.

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 05/02/2008
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 It happened while working and using the tools of the job.

REPORT SUBMITTED BY Ashley Postma DATE 05/06/2008
Administrative Assistant