#184
5-2-08
cc: CMG
5-2-08

SUZLON

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

Suzlon Accident Report

Team Member: David Smith

Taken to Hospital or Clinic? Y___ N V

Date of Occurrence: 4-30-08

Is This a Near Miss? Y___ N V Direct Hit

Time of Occurrence: 10:45

Date Reported: 4-30-08

Team Leader: Tanya Fangemire

Department: Prefab

Day shift V Night shift ___

Location of where accident occurred (*be specific*)

Prefab White Line Girders.

Description of accident / injury

While pulling girder he tripped on metal part that has bolt in floor to mount girder. Hit wrist [redacted] & forearm on left arm.

Witnesses names

Jim & John

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

Be more careful & pay attention to surroundings

Employee Feedback

David Smith — 4-30-08
Team Member Signature — Date

Tanya Fangemire — 4-30-08
Team Leader Signature — Date

Thomas Turk — 5-2-2008
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 05 2008
BY:_____

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.

FRO1

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY # 504-74-7487	2. OSHA Case #						
3. DATE OF CLAIMED INJURY 4/30/2008	4. Time of injury 10:45 ☑ am ☐ pm	5. Time employee began work on date of injury 07:00 ☑ am ☐ pm					
6. EMPLOYEE Name (last, first, middle) Smith David	7. Gender ☑ M ☐ F	8. Marital Status ☐ Married ☑ Unmarried					
9. Home address 333 S Spring Ave	10. Home phone # (605) 332-6730	11. Date of birth 6/11/1957					
City Sioux Falls	State SD	Zip Code 57104	12. Occupation Production Worker	13. Regular department Prefab	14. Date hired 4/14/2008		
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."*

Report only did not go to the clinic.
While pulling glass David tripped on metal part that has a bolt infloor to mount girder. David hit his wrist and forearm on 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* wrist and left arm	24. What tools, equipment, machines, objects, or substances were involved? *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard* glass, metal, bolt, grider

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 4/30/2008	29. Date employer notified of lost time
	30. Return to work date 4/30/2008	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	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) Jim and John	
City	State Zip Code	44. NAICS code	45. Date form completed 05/05/2008

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 05/05/2008	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 David Smith COMPANY CORPORATE MANAGEM DEPT. Prefab

DATE OF ACCIDENT 4/30/2008 TIME 10:45 AM DID EMPLOYEE LOSE TIME FROM WORK? YES ☐ NO ☑

HOURS LOST ON DATE OF ACCIDENT _____ 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.) Report only did not go to the clinic.
While pulling glass David tripped on metal part that has a bolt infloor to mount girder. David hit his

WITNESSES' NAMES Jim and John

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?)
N/A

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?)
Be more careful and pay attention to your surroundings.

MEDICAL CARE. DID EMPLOYEE GO TO DOCTOR OR HOSPITAL? YES ☐ NO ☑ IF YES, COMPLETE THE FOLLOWING

NAME OF DOCTOR OR HOSPITAL _____ DATE OF INITIAL VISIT _____

ADDRESS _____ TELEPHONE NUMBER _____

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

REASONS WHY Did not recieve medical treatment.

REPORT SUBMITTED BY Ashley Postma DATE 05/05/2008