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

Suzlon Accident Report

CMG copy 6-23-08

Team Member: Emanuel Colon Gonzalez

Taken to Hospital or Clinic? Y___ N X
will need to go to Dentist

Date of Occurrence: 3-26-08

Is This a Near Miss? Y___ N___

Time of Occurrence: 9:15

Date Reported: 3-26-08

Team Leader: Susan Klosterman

Department: Whiteline mould

Day shift X Night shift ___

Location of where accident occurred (*be specific*)

inside Oside mould (Whiteline)

Description of accident / injury

While laying surface veil after NC55 very slippery Emanuel fell on his face knocked out the filling of his front tooth + Bloody is nose - Couldn't find filling

Witnesses names

Mario Cornejo, Marcelino Ortiz Bayanville, Susan Klosterman

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

NC55 makes the surface very slippery use more Caution while in empty mould, maybe look in to getting slippers that won't slip.

Employee Feedback

Emmanuel A. Colon Gonzalez — 3-26-08
Team Member Signature — Date

Susan Klosterman — 3-26-08 — Recd 3-27-08
Team Leader Signature — Date

Thomas Funk — 3-27-08
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
JUN 24 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.

FR01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #
581-95-8526	

3. DATE OF CLAIMED INJURY	4. Time of injury	5. Time employee began work on date of injury
3/26/2008	09:15 ☑ am ☐ pm	07:00 ☑ am ☐ pm

6. EMPLOYEE Name (last, first, middle)		7. Gender	8. Marital Status
Colon Gonzalez	Emmanuel	☑ M ☐ F	☐ Married ☑ Unmarried

9. Home address	10. Home phone #	11. Date of birth
1218 4th Ave.	(507) 343-0046	10/17/1983

City	State	Zip Code	12. Occupation	13. Regular department	14. Date hired
Worthington	MN	56187	Production Worker	Mould	2/4/2008

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status
$400.00	$10.00	8	6	☑ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

20. Weekly value of:	Meals	Lodging	2nd income	21. Apprentice
	$0.00	$0.00	$0.00	☐ 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."*

While laying surface veil after NC55 very slippery Emmauel fell on his face and knocked out the filling of his front tooth and he received a bloody nose. Couldn't find filling.

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*	24. What tools, equipment, machines, objects, or substances were involved? *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard*
tooth, face, nose	veil, slippery surface

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: 3/26/2008	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	37. EMPLOYER DBA name (if different)
CORPORATE MANAGEMENT GROUP INC 188602	

38. Mailing address	39. Employer FEIN	40. Unemployment ID #
12000 N. WASHINGTON ST. #290		0036373110

City	State	Zip Code	41. Employer's contact name and phone #
THORNTON	CO	80241	Amanda Carnahan (303) 920-1425

42. Physical address (if different)	43. Witness (name and phone)
	Mario Cornjeo, Marcelino O[redacted]

City	State	Zip Code	44. NAICS code	45. Date form completed
				06/24/2008

46. INSURER name	51. CLAIMS ADMIN COMPANY (CA) name (check one)	Insurer	TPA
MINNESOTA ASSIGNED RISK PLAN	Berkley Risk Administrators Company, LLC		

47. Insured legal name	52. CA Address
	222 South Ninth Street

48. Policy # or self-insured certificate #	City	State	Zip Code
	Minneapolis	MN	55402

49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #
	06/24/2008	41-1887666	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 Emmanuel Colon Gonzalez COMPANY CORPORATE MANAGEM DEPT. Mould

DATE OF ACCIDENT 3/26/2008 TIME 9:15 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.) While laying surface veil after NC55 very slippery Emmauel fell on his face and knocked out the filling of his front tooth and he received a bloody nose. Couldn't find filling.

WITNESSES' NAMES Mario Cornjeo, Marcelino O[redacted]

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?)

Use caution while empty the mould.

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

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 Happened while working.

REPORT SUBMITTED BY Ashley Postma DATE 06/24/2008

Administrative Assistant