

Suzlon Accident Report

Team Member: Genevieve Muck Taken to Hospital or Clinic? Y N

Date of Occurrence: 3-27-08 Is This a Near Miss? Y N Direct Hit

Time of Occurrence: 11:00 am

Date Reported: 3-27-08 Team Leader: Tanya Fongemie

Department: Prefab Day shift Night shift

Location of where accident occurred (be specific)

Roofs in prefab

Description of accident / Injury

She has broke out in hives on stomach, shoulders, back, legs, arms and starting on neck

Witnesses names

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

Employee Feedback

Team Member Signature

Tanya Fongemie
Team Leader Signature

Date

3-27-08

Date

Thomas Turk
Safety Officer Signature

Date

4-4-2008

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
APR 04 2008

Health Care Provider Report

See Instructions on Reverse Side
(WHEN COMPLETED RETURN TO REQUESTER)



H C 0 1

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER <i>504 04 1806</i>	DATE OF INJURY <i>3-27-08</i>	DOB <i>7-28-83</i>
EMPLOYEE <i>Genevieve Munk</i>	EMPLOYER <i>Suzlon</i>	
INSURER/SELF-INSURER/TPA	INSURER CLAIM NUMBER	
INSURER ADDRESS		
CITY	STATE	ZIP CODE

REQUESTER must specify all items to be completed by health care provider. Items: _____ MMI (#9) PPD (#10)
HEALTH CARE PROVIDER TO COMPLETE ITEMS REQUESTED ABOVE

1. Date of first examination for this injury by this office: _____ (date)
2. Diagnosis (include all ICD-9-CM codes):
allergic dermatitis
3. History of injury or disease given by employee:
rash developed @ work on 3/26
4. In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? No Yes
5. Is there evidence of pre-existing or other conditions that affect this disability? No Yes If yes, describe: _____
6. Is further treatment of this injury or referral to another doctor planned? No Yes If yes, describe: _____
7. Has surgery been performed? No Yes If yes, date and describe: _____ (date)
8. Attach the most recent Report of Work Ability. Date of report: _____ (date)
9. Has the employee reached maximum medical improvement? (if yes, complete item #10) (See definition on back) No Yes Date reached: _____
10. Has the employee sustained any permanent partial disability from the injury? No Yes Too early to determine
The permanent partial disability is _____ % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

NAME (Type or Print) BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	SIGNATURE <i>B. Kocourek</i>	DEGREE <i>MD</i>
CITY UPIN D25406 NPI 1699738559	STATE	LICENSE #/REGISTRATION #
	AREA CODE	TELEPHONE #
		DATE SIGNED <i>3-27-08</i>

Report of Work Ability

See Instructions on Reverse Side



RW01

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)

DO NOT USE THIS SPACE

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 504041806	DATE OF INJURY 3-27-08
EMPLOYEE Genevieve Munk	Date of Birth 7-28-83
EMPLOYER Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 3-27-08 (date)

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

- Employee is able to work without restrictions as of 3/27/08 (date)
- Employee is able to work with restrictions, from (date) to (date)

The restrictions are:

- Employee is unable to work at all, from (date) to (date)

The next scheduled visit is: as needed OR (date)

NAME (Type or Print) BRUCE W KOCOUREK, DO	SIGNATURE 	DEGREE D
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		DATE SIGNED 3-27-08



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

Referral for Medical Treatment Report to Employer

Employee Name: Genevieve Munk Date of Injury: 3-27-08

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.

[Signature]
Employee Signature

3-27-08
Date

Medical Provider _____ Date / Time of Appt: 3-27-08 @ 1:30 pm

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
PO Box 8016
Wausau, WI 54402
1-877-870-1542

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

Diagnosis: allergic dermatitis _____ Non-work related
_____ Undetermined

Treatment Plan: medrol dosage, zyrtex _____ Work related

RETURN TO WORK: With No Limitations Date: 3/27/08
(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: protection

of fiberglass, wash frequently
Medical Provider Signature: B. Kaur... Date: 3/27/08



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_____ Other: _____

Next Appt. Date / Time: _____ Provider's Comments: protection of fiberglass, wash frequently

Medical Provider Signature: B. Rasmussen Date: 3/27/08

Health Care Provider Report

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(WHEN COMPLETED RETURN TO REQUESTER)

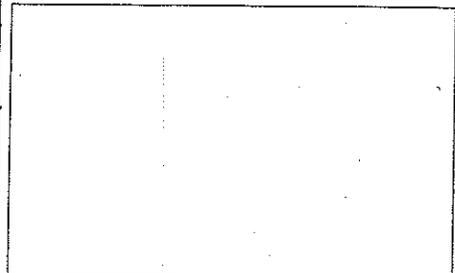


HC01

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RW01

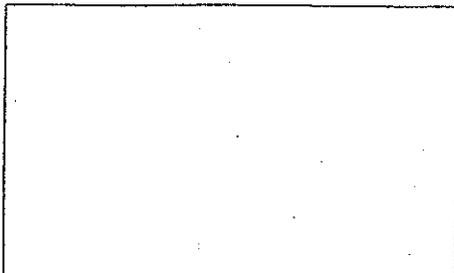
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