



Suzlon Accident Report

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

Team Member: Grisella Rivera Taken to Hospital or Clinic? Y N

Date of Occurrence: 10.29.7 Is This a Near Miss? Y N

Time of Occurrence: _____

Date Reported: 10.29.7 Team Leader: Radlocks

Department: Mat Prep/warehouse Day shift Night shift

Location of where accident occurred (be specific)

Mat Prep

Description of accident / injury

Reaction to the GLASS

Witnesses names

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

went to doctor and got some cream

Employee Feedback

wear gloves and use cream

Grisella Rivera
Team Member Signature

11-5-7
Date

Radlocks
Team Leader Signature

11-5-7
Date

Jason Ben
Safety Officer Signature

11-5-7
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



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 # 596.20.4028		2. OSHA Case # 	
3. DATE OF CLAIMED INJURY 10.29.07		4. Time of injury N/A	5. Time employee began work on date of injury 3:00 pm
6. EMPLOYEE Name (last, first, middle) Rivera Soto Mayor, Griselle		7. Gender M <input type="checkbox"/> F <input checked="" type="checkbox"/>	8. Marital Status Married <input type="checkbox"/> Unmarried <input checked="" type="checkbox"/>
9. Home address 1236 11th St.		10. Home phone # N/A	11. Date of birth 10.7.88
City Edgerton	State MN	Zip Code 56128	12. Occupation Teammate
13. Regular department Nosecones		14. Date hired 10/22/07	
15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week
19. Employment Status Full time <input type="checkbox"/> Seasonal <input type="checkbox"/> Part time <input type="checkbox"/> Volunteer <input type="checkbox"/>		21. Apprentice Yes <input type="checkbox"/> No <input type="checkbox"/>	
20. Weekly value of: Meals <input type="checkbox"/> Lodging <input type="checkbox"/> 2nd income <input type="checkbox"/>	22. Tell us how the injury occurred and what the employee was doing before the incident (give details). Working in Material Prep / Nosecones dept. cutting glass		
23. What was the injury or illness (include the part(s) of body)? Rash		24. What tools, equipment, machines, objects, or substances were involved? 	
25. Did injury occur on employer's premises? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		26. Date of first day of any lost time Report Only	27. Employer paid for lost time on day of injury (DOI) Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI <input type="checkbox"/>
If no, indicate name and address of place of occurrence		28. Date employer notified of injury 11/5/07	29. Date employer notified of lost time N/A
30. Return to work date N/A		31. Date of death 	
32. TREATING PHYSICIAN (name, address, and phone) B. Kocourek		33. HOSPITAL/CLINIC (name and address) (if any) Pipestone Medical 920 4th Ave SW Pipestone MN 56164	
34. Emergency Room Visit Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		35. Overnight in-patient Yes <input type="checkbox"/> No <input type="checkbox"/>	
36. EMPLOYER Legal name		37. EMPLOYER DBA name (if different)	
38. Mailing address		39. Employer FEIN	40. Unemployment ID #
City	State	Zip Code	41. Employer's contact name and phone #
42. Physical address (if different)		43. Witness (name and phone)	
City	State	Zip Code	44. NAICS code
45. Date form completed		46. INSURER name	
47. Insured legal name		51. CLAIMS ADMIN COMPANY (CA) name (check one) Berkley Risk Administrators Company, LLC	
48. Policy # or self-insured certificate #		52. CA Address 222 South Ninth Street	
49. Insurer FEIN		53. CA FEIN	
50. Date insurer received notice		54. Claim #	
55. Insurer TPA		City Minneapolis	
56. Insurer State		State MN	
57. Insurer Zip Code		Zip Code 55402	

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 Ginselle Rivera S.M. COMPANY _____ DEPT. Mat Prep/No
DATE OF ACCIDENT 10-29-07 TIME _____ DID EMPLOYEE LOSE TIME FROM WORK? YES NO
HOURS LOST ON DATE OF ACCIDENT _____ HAS EMPLOYEE RETURNED TO WORK? YES NO
JOB TITLE Production Teammate SERVICE WITH THE COMPANY _____ YEARS IN PRESENT JOB _____

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.) Working in dept. with fiberglass

WITNESSES' NAMES _____

UNSAFE ACTS. (WHAT DID THE EMPLOYEE OR ANOTHER PERSON DO INCORRECTLY?) _____

UNSAFE CONDITIONS. (WHAT UNGUARDED OR UNSAFE CONDITION OF MACHINERY, EQUIPMENT, BUILDING OR PREMISES WAS INVOLVED?) _____

ACTIONS TAKEN. (WHAT DID YOU DO TO CORRECT THE CONDITIONS WHICH CAUSED THIS INJURY?) _____

Should use coveralls everyday to keep out fiberglass

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 B. Kocurek DATE OF INITIAL VISIT 10-29-07
ADDRESS _____ TELEPHONE NUMBER 507-825-5701

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

REASONS WHY _____

REPORT SUBMITTED BY J. Fraser - HR Rep

DATE _____

ENTERED
BRAC 2520 (10/99)

Report of Work Ability

See Instructions on Reverse Side



RW01

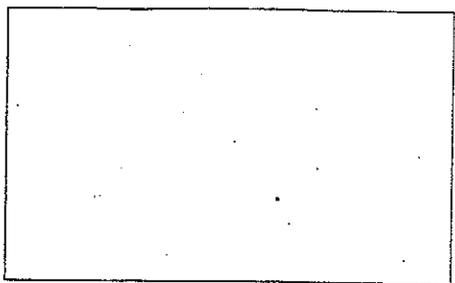
DO NOT USE THIS SPACE

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)

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 596204038	DATE OF INJURY 10-29-07
EMPLOYEE Griselle Rivera	Date of Birth 10-7-88
EMPLOYER	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	



Date of most recent examination by this office (date)

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

1. Employee is able to work without restrictions as of (date)
2. Employee is able to work with restrictions, from (date) to (date)
- The restrictions are:

3. 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 PIPESTONE MEDICAL GROUP	SIGNATURE <i>B. Kocourek</i>	DEGREE D
ADDRE 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	STATE	LICENSE #/REGISTRATION #
CITY UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #
		DATE SIGNED 10/29/07

ENTERED

Health Care Provider Report

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



HC01

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

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER <i>596 20 4038</i>	DATE OF INJURY <i>10-29-07</i>	DOB <i>10-7-88</i>
EMPLOYEE <i>Griselle Rivera</i>	EMPLOYER	
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: *10/29/07* (date)
2. Diagnosis (include all ICD-9-CM codes):
contact dermatitis - hands, feet, back
3. History of injury or disease given by employee:
rash itching p contact i resins @ work
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: *10/29/07* (date)
9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) No Yes Date reached: (date)
10. Has the employee sustained any permanent partial disability from the injury? No Yes Too early to determine
The permanent partial disability is 5223. % of the whole body. This rating is based on Minn. Rules:

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

NAME (Type or Print) BRUCE W KOCOUREK, DO PIPESTONE MEDICAL GROUP 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	SIGNATURE <i>B. Kocourek</i>	DEGREE <i>D</i>	STATE	LICENSE #/REGISTRATION #	AREA CODE	TELEPHONE #	DATE SIGNED <i>10/29/07</i>
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MN HC01 (7/01).

ENTERED