



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

### Suzlon Accident Report

Team Member: Griselle Rivera

Taken to Hospital or Clinic? Y  N

Date of Occurrence: 12-3-07

Is This a Near Miss? Y  N

Time of Occurrence: \_\_\_\_\_

Date Reported: 12-3-07

Team Leader: Randy Lykes

Department: Nose Cone

Day shift  Night shift

Location of where accident occurred (be specific)

Nose Cone Material Prep Area.

Description of accident / injury

dermatitis-

She had a reaction to the fiberglass fibers

Witnesses names

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

Lotion and were ~~less~~ clothes ~~not~~ that have not  
been overly exposed to fiberglass

Employee Feedback

Griselle Rivera

Team Member Signature

12.3.07

Date

Randy Lykes

Team Leader Signature

12.3.07

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*

**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 #<br>596-20-4038  |  | 2. OSHA Case #   |  |
| 3. DATE OF CLAIMED INJURY<br>12/3/2007  |  | 4. Time of injury<br><input type="checkbox"/> am<br><input type="checkbox"/> pm  | 5. Time employee began work on date of injury<br><input type="checkbox"/> am<br><input type="checkbox"/> pm  |
| 6. EMPLOYEE Name (last, first, middle)<br>Rivera-Sotomayor Griselle   |  | 7. Gender<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 8. Marital Status<br><input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Unmarried   |
| 9. Home address<br>11936 111th Street   |  | 10. Home phone #<br>(712) 441-6796   | 11. Date of birth<br>10/7/1988   |
| City<br>Leota   | State<br>MN                                    | Zip Code<br>56153  | 12. Occupation<br>Production Worker  |
| 13. Regular department<br>Nosecone  |  | 14. Date hired<br>11/5/2007  |  |
| 15. Average weekly wage<br>\$400.00   | 16. Rate per hour<br>\$10.60                   | 17. Hours per day<br>8   | 18. Days per week<br>6   |
| 19. Employment Status<br><input checked="" type="checkbox"/> Full time<br><input type="checkbox"/> Seasonal   |  | <input type="checkbox"/> Part time<br><input type="checkbox"/> Volunteer   |  |
| 20. Weekly value of:<br>Meals \$0.00<br>Lodging \$0.00  | 2 <sup>nd</sup> income \$0.00                  |  | 21. Apprentice<br><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."<br>Had a reaction to the fiberglass on her hands. |  |  |  |
| 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.<br>Hands  |  | 24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.<br>Fiberglass |  |
| 25. Did injury occur on employer's premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>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)<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> No lost time on DOI |
|   |  | 28. Date employer notified of injury<br>3/17/2008  | 29. Date employer notified of lost time  |
|   |  | 30. Return to work date<br>12/3/2007   | 31. Date of death  |
| 32. TREATING PHYSICIAN (name, address, and phone)<br>507-825-5700   |  | 33. HOSPITAL/CLINIC (name and address) (if any)<br>Pipstone Medical Group<br>920 4th Ave SW<br>Pipstone MN 56164   |  |
|   |  | 34. Emergency Room Visit<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   |  | 35. Overnight in-patient<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 36. EMPLOYER Legal name<br>CORPORATE MANAGEMENT GROUP INC 188602  |  | 37. EMPLOYER DBA name (if different)   |  |
| 38. Mailing address<br>12000 N. WASHINGTON ST. #290   |  | 39. Employer FEIN  | 40. Unemployment ID #<br>0036373110  |
| City<br>THORNTON  | State<br>CO                                    | Zip Code<br>80241  | 41. Employer's contact name and phone #<br>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<br>03/17/2008  |  |
| 46. INSURER name<br>MINNESOTA ASSIGNED RISK PLAN  |  | 51. CLAIMS ADMIN COMPANY (CA) name (check one) Insurer<br>Berkley Risk Administrators Company, LLC TPA   |  |
| 47. Insured legal name  |  | 52. CA Address<br>222 South Ninth Street   |  |
| 48. Policy # or self-insured certificate #  |  | City<br>Minneapolis  | State<br>MN  |
|   |  | Zip Code<br>55402  |  |
| 49. Insurer FEIN  | 50. Date insurer received notice<br>03/17/2008 | 53. CA FEIN<br>41-1887666  | 54. Claim #<br>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 Griselle Rivera-Sotomayor COMPANY CORPORATE MANAGEM DEPT. Nosecone  
DATE OF ACCIDENT 12/3/2007 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 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.) Had a reaction to the fiberglass on her hands.

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?) \_\_\_\_\_

Use lotion and ware garments that have not been overly expose to fiberglass.

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

Educate employees to cover their hands better and wash hands when expose to fiberglass.

**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 12/03/2007  
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 on the job and working with the materials.

REPORT SUBMITTED BY Ashley Postma

DATE 03/17/2008

Administrative Assistant