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

Suzlon Accident Report

Team Member: Jerold Braboy

Taken to Hospital or Clinic? Y X N ___

Date of Occurrence: 2-28-08

Is This a Near Miss? Y ___ N ___

Time of Occurrence: 8:22 A.M.

Date Reported: 2-28-08

Team Leader: Ken Klosterman

Department: Pre-fab

Day shift X Night shift ___

Location of where accident occurred (*be specific*)

Pre-fab finishing

Description of accident / injury

Jerold was grinding on a girder, the very end of a girder, when the grinder slip making Jerold hand hit the sharp edge of the girder

* Jerald was wearing his gloves at the time *

Witnesses names

none

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

instead of trying to grind the very end of the girder we need to use a diamond saw blade to cut it off.

Employee Feedback

Jerold Braboy — Team Member Signature — 2/28/08 — Date

Ken K — Team Leader Signature — 2-28-08 — 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*

RECEIVED
FEB 28 2008

F:SF:03 Rev Num:4 Rev Date: 16-Jul-07

BY:

ACCIDENT REPORTING PROCEDURES

Employees are required to report all job related injuries to your Manager or Human Resources immediately of the occurrence. *The Manager with the Employee will conduct an accident investigation.* Human Resources or the Manager may provide first aid treatment. If your injury needs to be seen by a medical provider:

1. A medical referral form must be picked up from the Human Resources or the Manager to take along to the medical provider before each medical visit (except for emergencies).

2. The completed medical referral form must be returned immediately to the Human Resources after the medical providers' visit along with the date and time of next appointment.

3. Any change in attending medical providers must be approved by the Insurance Carrier or coordinated with the Human Resources.

If your job assignment aggravates an already existing physical condition, notify your immediate Manager and Human Resources. A review of your job assignment will be made.

5. **Return to Work Assignments** are used to provide short-term work that accommodates restrictions of Employees as early as possible after an injury. Our goal is to maintain regular contact with the Employee, provide support, maintain a safe work environment during the convenient period, avoid pitfalls of disability and keep the person gainfully employed within their present medical restrictions until returned to their regular job. Medical placement in to a temporary return to work assignment is accomplished by written approval from a physician with the assistance from an Occupational Specialist and CMG Management.

Employees will be retained within their job classifications whenever possible. If the employee remains on restricted duty regular progress meetings will be scheduled. If the Employee cannot return to their regular job within a reasonable time period, (i.e. sixty to ninety calendar days) the Employee may be considered for alternate placement within CMG or Outplacement Rehabilitation.

Regular communication must be maintained with your Manager and Human Resources after any work related injury has occurred. *Future medical providers' visits or absences should be coordinated through Human Resources for accurate reporting of Employees medical condition.* Failure to comply with this policy may result in disciplinary action or cause a delay in Insurance benefits.

Clocking and pay procedure: Employee's if leaving the building will clock out and will not be paid by CMG while attending appointments. All lost time hours of pay will be paid by submitting by the employee to the insurance carrier and reimburse at 66 2/3% of their straight time wages (less applicable taxes) in accordance with State Worker's Compensation laws.

I have read received a copy and will comply with these procedures or be subject to disciplinary action up to and including termination of employment.

Employee Signature _____ Date: 2/26/08

Medical Referral to Employer

Employee Name: Jerard Brabec **Date of Injury:** _____

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.

Jerard Brabec
Employee Signature

_____
Date

Medical Provider _____ **Date / Time of Appt:** _____

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:

Berkley Risk
PO BOX 59143
Minneapolis, MN 55459-0413
(612)766-3000

Incomplete billings or those mailed directly to Corporate Management Group may result in slow payment processes.

Diagnosis: 3.5 x 0.2cm laceration (L) hand

Treatment Plan: suture repair

_____ **Non-work related**

_____ **Undetermined**

__✓__ **Work related**

RETURN TO WORK: __✓__ **With No Limitations** **Date:** 2/28/08

(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: 10d. **Provider's Comments:** keep wound covered, clean + dry

Medical Provider Signature: B. Rockwood **Date:** 2/28/08

Please fax back to 507.562.6800 – Attn CMG.

FITNESS FOR DUTY

Employees who are absent due to illness or injury (either work-related or non-occupational) may be required to have their physician or other qualified health provider complete a Fitness for Duty Certification before returning to work. The completed form should be returned to Human Resources will make a determination as to his/her ability to return to work. No employee will be allowed to return to work without a satisfactory Fitness for Duty Certification on file.

Employee Name: Gerard Brabey Date: 2/28/08

Is employee able to perform the functions of his/her position? X Yes ___ No

Any restrictions? ___ Yes X No If yes, please describe restriction(s) and duration below:

RETURN TO WORK: X With No Limitations Date: 2/28/08

(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: _____

wound care instructions

Employee Signature: _____

Physician or Practitioner Signature: _____

Type of Practice: (Field of Specialization) FP

Please fax back to 507.562.6800 – Attn CMG.

Report of Work Ability

See Instructions on Reverse Side

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

RW01

DO NOT USE THIS SPACE

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	DATE OF INJURY
343 68 2800	2-28-08
EMPLOYEE: Gerard Bradley	Date of Birth: 2-3-71
EMPLOYER: CMS Swfon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 2/28/08 (date)

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

1. ☐ Employee is able to work without restrictions as of 2/28/08 (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 3/10/08 (date)

NAME (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONE DCOUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	B Kocourek	
ADDRESS	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE / TELEPHONE #	DATE SIGNED: 2/28/08

MN RW01 (7/01)

Health Care Provider Report

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

HC01

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
343682800	2-28-08	2-3-71
EMPLOYEE: Gerard Brabrey	EMPLOYER: CMG. Senior Rolla	
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: 2/28/08 (date)

2. Diagnosis (include all ICD-9-CM codes):
3.5 x 0.2cm laceration ② hand

3. History of injury or disease given by employee:
cut hand with grinder

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: 2/28/08 (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 ADDRES PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 CITY DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	SIGNATURE B. Kocourek DO	DEGREE
	STATE	LICENSE #/REGISTRATION #
	AREA CODE	TELEPHONE # / DATE SIGNED 2/28/08

MN HC01 (7/01).

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	DATE OF INJURY
343 68 2800	2-28-08
EMPLOYEE: Gerard Bradley	Date of Birth: 2-3-71
EMPLOYER: CMS Sanford Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 2/28/08 (date)

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

1. ☐ Employee is able to work without restrictions as of 2/28/08 (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 3/10/08 (date)

NAME (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONE DCOUNTY MEDICAL CENTER ADDRESS 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 CITY UPIN D25406 NPI 1699738559	B Kocourek	
	STATE	LICENSE #/REGISTRATION #
	AREA CODE / TELEPHONE #	DATE SIGNED: 2/28/08

MN RW01 (7/01)

Health Care Provider Report

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

HC01

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
343682800	2-28-08	2-3-71
EMPLOYEE: Gerard Bradley	EMPLOYER: C.M.E. Senior Rodeo	
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: 2/28/08 (date)
2. Diagnosis (include all ICD-9-CM codes):
   3.5 x 0.2cm laceration ② hand
3. History of injury or disease given by employee:
   cut hand with grinder
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: 2/28/08 (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)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO	B. Kocourek	
ADDRESS: PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE / TELEPHONE #	DATE SIGNED: 2/28/08

MN HC01 (7/01).

FITNESS FOR DUTY

Employees who are absent due to illness or injury (either work-related or non-occupational) may be required to have their physician or other qualified health provider complete a Fitness for Duty Certification before returning to work. The completed form should be returned to Human Resources will make a determination as to his/her ability to return to work. No employee will be allowed to return to work without a satisfactory Fitness for Duty Certification on file.

Employee Name: Edward Bradley Date: 2/28/08

Is employee able to perform the functions of his/her position? X Yes ___ No

Any restrictions? ___ Yes X No If yes, please describe restriction(s) and duration below:

RETURN TO WORK: X With No Limitations Date: 2/28/08

(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: _____

wound care instructions

Employee Signature: _____

Physician or Practitioner Signature: _____

Type of Practice: (Field of Specialization) FP

Please fax back to 507.562.6800 – Attn CMG.

Medical Referral to Employer

Employee Name: Jerrad Brabec **Date of Injury:** 2-28-08

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.

Employee Signature — Date: 2-28-08

Medical Provider BWK **Date / Time of Appt:** _____

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:

Berkley Risk
PO BOX 59143
Minneapolis, MN 55459-0413
(612)766-3000

Incomplete billings or those mailed directly to Corporate Management Group may result in slow payment processes.

Diagnosis: 3.5 x 0.7cm laceration (L) hand

Treatment Plan: suture repair

____ **Non-work related**
____ **Undetermined**
✓ **Work related**

RETURN TO WORK: ✓ **With No Limitations** **Date:** 2/28/08

(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: 10d. **Provider's Comments:** keep wound covered, clean + dry,

Medical Provider Signature: B. Rasmussen **Date:** 2/28/08

Please fax back to 507.562.6800 – Attn CMG.

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 #	2. OSHA Case #
343-68-2800	

3. DATE OF CLAIMED INJURY	4. Time of injury		5. Time employee began work on date of injury	
2/28/2008	08:22	☑ am ☐ pm	07:00	☑ am ☐ pm

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

9. Home address	10. Home phone #	11. Date of birth
4713 S. Baha	(605) 521-1517	2/3/1971

City	State	Zip Code	12. Occupation	13. Regular department	14. Date hired
Sioux Falls	SD	57106	Production Worker	Prefab	2/18/2008

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status			
$400.00	$10.00	8	5	☑ Full time ☐ Seasonal	☐ Part time ☐ 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."*

Jerard was grinding on a girder, the very end of a girder, when the grinder slip making Jerard's hand hit the sharp edge of the girder. Jerard was wearing his gloves at the time.

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*
hand	Grinder, girder

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: 2/28/2008	29. Date employer notified of lost time
	30. Return to work date: 2/28/2008	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit	35. Overnight in-patient
507-825-5700	Pipestone Medical Group 920 4th Ave SW Pipestone MN 56164	☑ Yes ☐ No	☐ Yes ☑ No

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
CORPORATE MANAGEMENT GROUP INC 188602		
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)	
City State Zip Code	44. NAICS code	45. Date form completed: 02/28/2008

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: Minneapolis State: MN Zip Code: 55402	
49. Insurer FEIN	50. Date insurer received notice: 02/28/2008	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 Jerard Braboy COMPANY CORPORATE MANAGEM DEPT. Prefab

DATE OF ACCIDENT 2/28/2008 TIME 8:22 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 2 mo YEARS IN PRESENT JOB 2mo

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.) Jerard was grinding on a girder, the very end of a girder, when the grinder slip making Jerard's hand hit the sharp edge of the girder. Jerard was wearing his gloves at the time.

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?)

Was instructed to use a diamond saw blade instead of a grinder.

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

They should make sure employees are using correct tools.

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 02/28/2008

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 Happened at work

REPORT SUBMITTED BY Ashley Postma DATE 02/28/2008

Administrative Assistant