



Suzlon Accident Report

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

Team Member: Jesslyn Figueroa

Taken to Hospital or Clinic? Y N

Date of Occurrence: 6/24/08

Is This a Near Miss? Y N

Time of Occurrence: _____

Date Reported: 6/25/08

Team Leader: LISA Gorter

Department: Nosecones

Day shift Night shift

Location of where accident occurred (be specific)

Nosecones

Description of accident / injury

Reaction to Resin on right arm, between elbow and wrist.

Witnesses names

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

Employee Feedback

Jesselyn Figueroa

Team Member Signature

6-25-08

Date

Lisa Gorter

Team Leader Signature

6/25/08

Date

Thomas Fuchs

Safety Officer Signature

6-25-2008

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 25 2008



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 Jesselyn Figueroa Date: 6-25-08

Health Care Provider Report

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



H C O 1

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER	DATE OF INJURY <i>6-25-08</i>	DOB <i>12-29-76</i>
EMPLOYEE <i>Jesselyn Figueroa</i>	EMPLOYER <i>CMG</i>	
INSURER/SELF-INSURER/TPA <i>CMG</i>	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: *6-25-08* (date)
2. Diagnosis (include all ICD-9-CM codes):
contact dermatitis
3. History of injury or disease given by employee:
rash on @ arm 2° resin exposure
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: *6/25/08* (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:

<i>5223.</i>	%	<i>5223.</i>	%	<i>5223.</i>	%
<i>5223.</i>	%	<i>5223.</i>	%	<i>5223.</i>	%

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 CITY UPIN D25406 NPI 1699738559	SIGNATURE <i>B. Kourek</i> STATE LICENSE #/REGISTRATION # AREA CODE TELEPHONE # DEGREE DATE SIGNED <i>6/25/08</i>
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Report of Work Ability

See Instructions on Reverse Side



R W 0 1

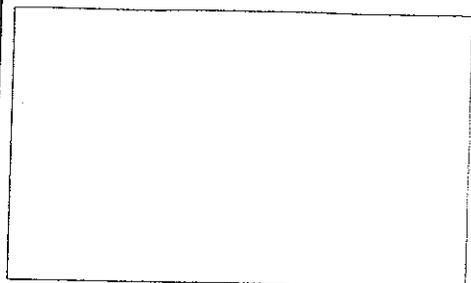
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

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		DATE OF INJURY 6-21-08	
EMPLOYEE Jesselyn Figueroa		Date of Birth 12-29-76	
EMPLOYER CMG			
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)	SIGNATURE <i>B. Kourek</i>		DEGREE
ADDRESS BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744	STATE	LICENSE #/REGISTRATION #	
CITY DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #	DATE SIGNED 6/25/08



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: Jesselyn Figueroa Date: 6/25/08

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

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

RETURN TO WORK: With No Limitations Date: 6/25/08

(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: _____

Employee Signature: _____

Physician or Practitioner Signature: B. Raunio

Type of Practice: (Field of Specialization) FP

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 # 584-81-9990		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 6/24/2008		4. Time of injury 10:30	<input checked="" type="checkbox"/> am <input type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Figueroa Jesselyn		7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried
9. Home address 904 Hackberry Dr. Apt # 10		10. Home phone # (507) 401-6279	11. Date of birth 12/29/1976
City Marshall	State MN	Zip Code 56258	12. Occupation Production Worker
13. Regular department Nosecones		14. Date hired 6/16/2008	
15. Average weekly wage \$400.00	16. Rate per hour \$10.00	17. Hours per day 8	18. Days per week 6
19. Employment Status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Seasonal		<input type="checkbox"/> Part time <input type="checkbox"/> Volunteer	
20. Weekly value of: Meals \$0.00 Lodging \$0.00	2 nd income \$0.00	21. Apprentice <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." Recation to the resin on right arm, between elbow and wrist.			
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 right arm		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. resin	
25. Did injury occur on employer's premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 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 6/24/2008	31. Date of death
32. TREATING PHYSICIAN (name, address, and phone) 507-825-5700		33. HOSPITAL/CLINIC (name and address) (if any) Pipestone Medical Group 920 4th Ave SW Pipestone MN 56164	
		34. Emergency Room Visit <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		35. Overnight in-patient <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
36. EMPLOYER Legal name CORPORATE MANAGEMENT GROUP INC 188602		37. EMPLOYER DBA name (if different)	
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) N/A	
City	State	Zip Code	44. NAICS code
		45. Date form completed 06/25/2008	
46. INSURER name MINNESOTA ASSIGNED RISK PLAN		51. CLAIMS ADMIN COMPANY (CA) name (check one) Insurer Berkley Risk Administrators Company, LLC TPA	
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 06/25/2008	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 Jesselyn Figueroa COMPANY CORPORATE MANAGEM DEPT. Nosecones
DATE OF ACCIDENT 6/24/2008 TIME 10:30 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 2 mo YEARS IN PRESENT JOB 2 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.) Recation to the resin on right arm, between elbow and wrist.

WITNESSES' NAMES N/A

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?)

N/A

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

N/A

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 06/25/2008
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 It happened while using the materials of the job.

REPORT SUBMITTED BY Ashley Postma

DATE 06/25/2008

Administrative Assistant