

**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 # 390-96-5902		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 11/5/2007		4. Time of injury 04:00 <input type="checkbox"/> am <input checked="" type="checkbox"/> pm	5. Time employee began work on date of injury 03:00 <input type="checkbox"/> am <input checked="" type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Volden Jessie		7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried
9. Home address 112 N. Buckingham St.		10. Home phone # (507) 370-5226	11. Date of birth 4/16/1985
City Hardwick	State MN	Zip Code 56134	12. Occupation Production Teammate
13. Regular department Nose Cones		14. Date hired 10/22/2007	
15. Average weekly wage	16. Rate per hour \$10.60	17. Hours per day 8	18. Days per week 5
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: Lodging: 2 <sup>nd</sup> income:	
21. Apprenticeship <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." Working in dept. with fiberglass	
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. Rash		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. Fiberglass	
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 1711 S. HWY 75 Pipestone MN 56164		26. Date of first day of any lost time Report Only	27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No lost time on DOI
28. Date employer notified of injury 11/6/2007		29. Date employer notified of lost time	
30. Return to work date		31. Date of death	
32. TREATING PHYSICIAN (name, address, and phone) Michael Lastin 920 4th Ave. SW Pipestone MN 56164 (507) 825-5700		33. HOSPITAL/CLINIC (name and address) (if any)	
34. Emergency Room Visit <input type="checkbox"/> Yes <input checked="" 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 # Jessica (507) 562-6713
42. Physical address (if different)		43. Witness (name and phone)	
City	State	Zip Code	44. NAICS code
		45. Date form completed 11/19/2007	
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 11/19/2007	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 Jessie Volden COMPANY CORPORATE MANAGEM DEPT. Nose Cones  
 DATE OF ACCIDENT 11/5/2007 TIME 4:00 PM 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 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?) \_\_\_\_\_

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

Must wear coveralls to keep out fiberglass

**MEDICAL CARE.** DID EMPLOYEE GO TO DOCTOR OR HOSPITAL? YES  NO  IF YES, COMPLETE THE FOLLOWING

NAME OF DOCTOR OR HOSPITAL Michael Lastin DATE OF INITIAL VISIT 11/06/2007  
 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 Yes, I believe it's from the fiberglass; however I think she should've reported it sooner to remedy

REPORT SUBMITTED BY Mike Petronek  
(507) 562-6701

DATE 11/19/2007

ENTERED  
BRAC 2320 (10/99)

Pipestone County Medical Ctr  
Pipestone, MN 507-825-5811

VOLDEN, JESSIE  
ACCT#: H0241835 MR#: H044152  
ER 04/16/85 22 F  
11/06/07 LASTINE, MICHAEL L., M

Discharge Date 11/06/07 Time: 2040

DIAGNOSIS: Contact dermatitis

DIET: As before  
Activity As tolerates

Medication, Dose, When to take it, Why you take it  
: May take Benadryl 25mg every 6 hours as needed for itching  
: New prescriptions to fill tomorrow:  
: Topicort emollient cream apply 3-4 times as needed to rash

Physician orders/Special instructions:  
: Recommend to avoid fiberglass contact. Limit fume exposure due to  
: pregnancy.

If you need assistance, call MD at: Clinic 507-825-5700 or Hospital 507-825-5811

Return Appointments:  
: As needed

Discharge to Home/Self care  
Accompanied by Self per Ambulatory  
T 99.5 P 94 R 20 B/P 116/69 Wt in lbs: 210

Allergies: Dicloxacillin

Comments

The above information has been explained to my satisfaction and understanding.  
I have no unanswered questions or concerns.

\_\_\_\_\_  
(Patient's or family member's signature.)

\_\_\_\_\_  
Instructions given by/RN co-signature (if applicable)

\_\_\_\_\_  
Physician Signature (optional)

Nursing ED/OP Discharge Summary

(permanent part of the Medical Record)  
(Signed copy to Medical Records and copy to Patient)  
Run on 11/06/07 at 2039

ENTERED



# 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 r  
ved to return to work without a satisfactory

127680 07263-00019 -  
VOLDEN, JESSIE L  
F 04/16/85 22Y 09/20/07 1321  
JERSTAD, J P UNKNOWN

Employee Name: \_\_\_\_\_

Date: 9/20/07

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: 9/20/07

(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: Jessie will restart her medication today and follow up with her psychiatrist next week.

Employee Signature: \_\_\_\_\_

Physician or Practitioner Signature: John P. Jerstad, M.D.

Type of Practice: (Field of Specialization) EA / Int med.