



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

Suzlon Injury Report

5-20-08

CMH
6-10-08

Team Member: Joel Cruz Diaz
 Date of Occurrence: 20 May 08
 Time of Occurrence: 70:40 AM
 Department: Finishing
 Team Leader: Joel Swenson
 Date Reported: 20 May 08

If taken to Doctor, fill out this section
 Date of Treatment: 5-20-08
 Time of Treatment: 2:40
 Doctor: _____
 Drug Test Performed: Yes No
 Drug test date & time: _____

Location of where accident occurred (be specific)

Blue Line area of Finishing

Description of accident / injury

While Phillip Hudson was replacing a broom on the hangers, he brought the broom back over his head and accidentally struck Joel in the head. Joel has a large bump and has a headache.

Witnesses names

Phillip Hudson

Corrective action (include: task, equipment, environmental, and management factors) - If needs further investigation use form F:ST:02

People need to be aware of their surroundings when performing overhead tasks

Employee Feedback

Joel Cruz Diaz

Team Member Signature

5-20-08
Date

Joel Swenson

Manager Signature

5-20-08
Date

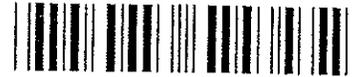
Thomas Fute

Human Resources Signature

5-20-08
Date

Health Care Provider Report

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

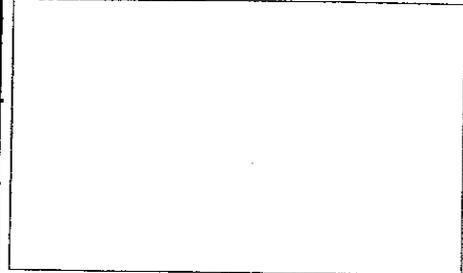


H C O 1

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>5-20-08</i>	DOB <i>12-12-80</i>
EMPLOYEE <i>Joel Cruz-Diaz</i>	EMPLOYER <i>Suzlon</i>	
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: *5-20-08* (date)
2. Diagnosis (include all ICD-9-CM codes):
Concussion
3. History of injury or disease given by employee:
Hit in head by broom
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: *5-20-08* (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 <i>HEIDI M. THORESON, PA</i> PIPESTONE MEDICAL GROUP 920 4TH AVE SW, PIPESTONE, MN 56164 507-825-5700 FAX 507-825-5895 DEA- MT1547833 MN LISC-10239 UPIN Q75758 NPI - 1689722027	SIGNATURE STATE _____ LICENSE #/REGISTRATION # _____	DEGREE <i>PA-C</i>
CITY _____	DE _____	AREA CODE _____ TELEPHONE # _____
		DATE SIGNED <i>5-20-08</i>

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 5-20-08	
EMPLOYEE Joel Cruz Diaz		Date of Birth 12-12-80	
EMPLOYER Suzlon			
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) EIDI M. THORESON, PA PIPESTONE FAMILY CLINIC		SIGNATURE Heidi Thoreson		DEGREE PA-C	
ADDRESS 20 4TH AVE SW, PIPESTONE, MN 56164 37-825-5700 FAX 507-825-5895 EA- MT1547833 MN LISC-10239		STATE		LICENSE #/REGISTRATION #	
CITY PIN Q75758 NPI - 1689722027		AREA CODE		TELEPHONE #	
				DATE SIGNED 5-20-08	



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

Referral for Medical Treatment Report to Employer

Employee Name: Joel Cruz-Diaz Date of Injury: 5-20-2008

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 _____

Medical Provider _____ Date / Time of Appt: 2:40

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:

**Wausau Insurance
PO Box 8016
Wausau, WI 54402**

1-877-870-1542

Incomplete billings or those mailed directly to Suzlon Rotor Corporation may result in slow payment processes.

Diagnosis: Concussion _____ Non-work related

_____ Undetermined

Treatment Plan: Pain medication _____ Work related

RETURN TO WORK: With No Limitations Date: 5-20-08

(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: _____

Medical Provider Signature: Heidi Thoreson Date: 5-20-08

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 # 582-83-7770		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 5/20/2008		4. Time of injury 10:40 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	5. Time employee began work on date of injury 07:00 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Cruz Diaz Joel		7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried
9. Home address 322 S. Duluth Ave Apt #3		10. Home phone # (605) 503-4770	11. Date of birth 12/12/1980
City Sioux Falls	State SD	Zip Code 57104	12. Occupation Production Worker
13. Regular department Finishing		14. Date hired 3/17/2008	
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"/> Part time <input type="checkbox"/> Seasonal <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." While Phillip Hudson was replacing a broom on the hangers, when brought the broom back over his head and accidentally struck Joel in the head. Joel has a large lump and headaches.	
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. head		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. broom	
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 6/10/2008	29. Date employer notified of lost time
		30. Return to work date 5/20/2008	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) Phillip Hudson	
City	State	Zip Code	44. NAICS code
		45. Date form completed 06/10/2008	
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 06/10/2008	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 Joel Cruz Diaz COMPANY CORPORATE MANAGEM DEPT. Finishing
DATE OF ACCIDENT 5/20/2008 TIME 10:40 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 4 mo YEARS IN PRESENT JOB 4 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 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.) While Phillip Hudson was replacing a broom on the hangers, when brought the broom back over his head and accidentally struck Joel in the head. Joel has a large lump and headaches.

WITNESSES' NAMES Phillip Hudson

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?)

Educate employees that they need to be aware of their surroundings when performing overhead tasks.

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 Pipestone Medical Group DATE OF INITIAL VISIT 05/20/2008
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 performing the duties of the job and use the tools of the job.

REPORT SUBMITTED BY Ashley Postma

DATE 06/10/2008

Administrative Assistant