257
6-25-08
OSHA 59
CMH copy
6-25-08

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

Suzlon Accident Report

Team Member: Katherine Quinones Morales Taken to Hospital or Clinic? Y X N ___

Date of Occurrence: 6-24-08 Is This a Near Miss? Y ___ N X

Time of Occurrence: 6:20 PM

Date Reported: 6-24-08 Team Leader: Mike Kelken

Department: Mould Day shift ___ Night shift X

Location of where accident occurred (*be specific*)

White line O-Side at 25M

Description of accident / injury

Was shelling aiding Mat. Slipped on some green mesh, fell landing on her wrist.

Witnesses names

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

Needs new boots. After so long boots get full of resin & pasta making them slippery.

Employee Feedback

KATHERINE @ MORALES — **Team Member Signature** 6/24/08 — **Date**

Mike Kelken — **Team Leader Signature** 6-24-08 — **Date**

Thomas Funk — **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*

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 Katherine G Morales Date: 6/25/08

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

Referral for Medical Treatment Report to Employer

Employee Name: Katherine Quinones Morales **Date of Injury:** 6-24-08

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 _____

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:

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: Minimally displaced (R)Left Radius Fracture ____ **Non-work related**

_____ ____ **Undetermined**

Treatment Plan: Splint today - Follow up with ortho on Thursday 6/26/08 X **Work related**

RETURN TO WORK: ____ **With No Limitations** **Date:** _____

(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:** 3 (Days)/Weeks

____ Restricted Work Hours: May Work 8 hours per day _____ hours per week.
X Restricted Lifting: Maximum lift: (10lbs) 20lbs 30lbs 40lbs 50lbs
Weight limit for repetitive lifting or carrying: (more frequent than 2 times per hour)
X 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: X 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:** _____

Dr. Donahue Thursday 6-26-08

Medical Provider Signature: _____ **Date:** 6-24-08

Morales
3:50 PM

1

Pipestone County Medical Ctr

Pipestone, MN 507-825-5811

MORALES,KATHERINE
ACCT#:H0269648 MR#:H047321
ER 02/04/74 34 F
06/24/08 BALT,DAVID A., DO

Discharge Date 06/24/08 Time: 2020

DIAGNOSIS: Fall with fracture to right wrist

DIET: Regular
Activity As tolerates

Medication, Dose, When to take it, Why you take it
: Vicodin 5/500mg: Take 1-2 tablets every 4-6 hours as needed for pain.
: May take a pain pill in 2 hours with food.

Physician orders/Special instructions:
: *** ER - Soft Tissue ***
: 1. Apply cold packs for 20 MINUTES EVERY 2 HOURS.
: 2. Elevate involved area.
: 3. Activity: NO WORK UNTIL CLEARED BY DR. DONAHUE
: 4. KEEP BRACE ON UNTIL SEEN BY DR. DONAHUE
: 5. KEEP ARM IN THE SLING UNTIL SEEN BY DR. DONAHUE

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

Return Appointments:
: Follow up with Dr.Donahue on Thursday.
: Call for appointment: 1-888-336-5311, then pick option #2. Call tomorrow

Discharge to Home/Self care
Accompanied by Other per Ambulatory
T 98.1 P 70 R 16 B/P 144/94 Wt in lbs:

Allergies: NKA

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 06/24/08 at 2023

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.

FR01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #
583-17-5741	

3. DATE OF CLAIMED INJURY	4. Time of injury	5. Time employee began work on date of injury
6/24/2008	06:20 ☐ am ☑ pm	03:45 ☐ am ☑ pm

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

9. Home address	10. Home phone #	11. Date of birth
1308 McMillan Street	(507) 727-0004	2/4/1974

City	State	Zip Code	12. Occupation	13. Regular department	14. Date hired
Worthington	MN	56187	Production Worker	Mould	5/21/2008

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status
$424.00	$10.60	8	6	☑ Full time ☐ Part time ☐ Seasonal ☐ 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."*

Was sheeling aiding mat. Slipped on some green mesh and fell on her 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*	24. What tools, equipment, machines, objects, or substances were involved? *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard*
right wrist	green mesh, shelling

25. Did injury occur on employer's premises?	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI)
☑ Yes ☐ No If no, indicate name and address of place of occurrence		☐ Yes ☐ No ☑ 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)	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	39. Employer FEIN	40. Unemployment ID #
12000 N. WASHINGTON ST. #290		0036373110

City	State	Zip Code	41. Employer's contact name and phone #
THORNTON	CO	80241	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	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	State	Zip Code
	Minneapolis	MN	55402

49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #
	06/25/2008	41-1887666	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 Katherine Quinones Morales COMPANY CORPORATE MANAGEM DEPT. Mould

DATE OF ACCIDENT 6/24/2008 TIME 6:20 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 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 ☑	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.) Was sheeling aiding mat. Slipped on some green mesh and fell on her 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?)

Needs new boots. After so long boots get full of resin and paste making them slippery.

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 06/24/2008

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 working with the materials and tools of the job.

REPORT SUBMITTED BY Ashley Postma DATE 06/25/2008

Administrative Assistant

BRAC 2520 (10/99)