



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

Suzlon Accident Report

Team Member: Kathy topete

Taken to Hospital or Clinic? Y__ N__

Date of Occurrence: 12-24-07

Is This a Near Miss? Y__ N__

Time of Occurrence: 8:50 Am

Date Reported: 12-24-07

Team Leader: Ken Klosterman

Department: Pre-fab

Day shift Night shift

Location of where accident occurred (be specific)

Pre-fab - roots

Description of accident / injury

she was the glass puller, and when she went to her left side her knee started to hurt her (it's her right knee)

Witnesses names

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

Employee Feedback

X Kathy N topete
Team Member Signature

X 12-24-07
Date

Ken [Signature]
Team Leader Signature

12-24-07
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

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 "CHANGE" 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 Kathy Topete COMPANY Suzlon DEPT. Pre-fab
DATE OF ACCIDENT 12-24-07 TIME 8:50 Am DID EMPLOYEE LOSE TIME FROM WORK? YES NO
HOURS LOST ON DATE OF ACCIDENT _____ HAS EMPLOYEE RETURNED TO WORK? YES NO
JOB TITLE Team Member on roots 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 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.) Kathy was the glass puller on roots, when she went to her left side with the glass, her right knee started to hurt her

WITNESSES' NAMES _____

UNSAFE ACTS. (WHAT DID THE EMPLOYEE OR ANOTHER PERSON DO INCORRECTLY?) no

UNSAFE CONDITIONS. (WHAT UNGUARDED OR UNSAFE CONDITION OF MACHINERY, EQUIPMENT, BUILDING OR PREMISES WAS INVOLVED?) none.

ACTIONS TAKEN. (WHAT DID YOU DO TO CORRECT THE CONDITIONS WHICH CAUSED THIS INJURY?) talk to her about moving her body with the glass movement

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?) talk to everyone about moving there bodys with the movement of glass.

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

NAME OF DOCTOR OR HOSPITAL _____ DATE OF INITIAL VISIT 12-26-07

ADDRESS pipestone, mn 56164 TELEPHONE NUMBER 825-5700

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES NO

REASONS WHY _____

REPORT SUBMITTED BY Ken Klosterman DATE 12-24-07



Medical Referral to Employer

Employee Name: Kathy Nereedo Topete Date of Injury: 12/26/07

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.

Kathy M Topete
Employee Signature

12-26-07
Date

Medical Provider Larry D. Christensen Date/Time of Appt: 12/26/07

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:

1-507-825-5700

**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: Knee Injury Non-work related

Treatment Plan: Knee Brace Undetermined 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: 12-26-07 To: 1-2-08

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: 1-2-08 Provider's Comments: _____

Medical Provider Signature: [Signature] Date: 12/26/07

Report of Work Ability

See Instructions on Reverse Side



R W O 1

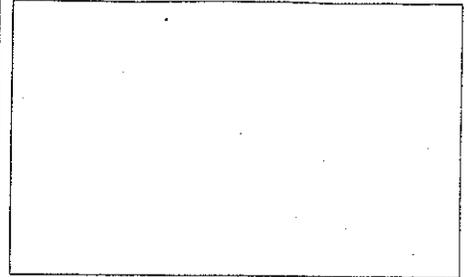
DO NOT USE THIS SPACE

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 605240354	DATE OF INJURY 12-24-07 12-22-07
EMPLOYEE Kathy Topete	Date of Birth 11-3-81
EMPLOYER CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	



Date of most recent examination by this office **12-26-07** (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 **12-26-07** (date) to (date)

The next scheduled visit is: as needed OR (date) **1-2-08**

NAME (Type or Print) LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP	SIGNATURE <i>Larry D Christensen</i>	DEGREE MD
ADDRESS 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 FAX 507-825-4744 DEA-AC7916539 MN LISC-23799 UPIN D75623	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE	TELEPHONE #
		DATE SIGNED 12/26/07

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 # 605-24-0354		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 12/24/2007		4. Time of injury 08:50 <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) Topete Kathy		7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Unmarried
9. Home address 1028 Diagonal Road		10. Home phone # (507) 372-7526	11. Date of birth 11/3/1981
City Worthington	State MI	Zip Code 56187	12. Occupation laborer
13. Regular department prefab		14. Date hired 10/22/2007	
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: Lodging: 2 nd income:	
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." moved to right, right knee popped/pain	
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 knee popped and pain resulted		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.	
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 Suzlon Rotor Pipestone MN 56164		26. Date of first day of any lost time 12/26/2007	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 12/24/2007		29. Date employer notified of lost time 12/26/2007	
30. Return to work date 1/2/2008		31. Date of death	
32. TREATING PHYSICIAN (name, address, and phone) Christensen 920 4th street SW Pipestone MN 56164 (507) 825-5700		33. HOSPITAL/CLINIC (name and address) (if any) Pipestone Family clinic 920 4th street SW Pipestone MN 56164	
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 # Eileen Stephenson (507) 562-6808
42. Physical address (if different)		43. Witness (name and phone)	
City	State	Zip Code	44. NAICS code
		45. Date form completed 12/26/2007	
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 12/26/2007	53. CA FEIN 41-1887666	54. Claim # 04 - 188602 -

SUPERVISOR'S REPORT OF ACCIDENT
(PLEASE READ AND FOLLOW INSTRUCTIONS ON BACK)

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NAME OF EMPLOYEE Kathy Topete COMPANY CORPORATE MANAGEM DEPT. prefab
DATE OF ACCIDENT 12/24/2007 TIME 8:50 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 laborer SERVICE WITH THE COMPANY 0 YEARS IN PRESENT JOB 0

**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"/> |
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| 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"/> |
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ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.) moved to right, right knee popped/pain

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?) _____

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

NAME OF DOCTOR OR HOSPITAL Christensen DATE OF INITIAL VISIT 12/26/2007
ADDRESS 920 4th street 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 _____

REPORT SUBMITTED BY C Leach DATE 12/26/2007
(507) 562-6750

Report of Work Ability

See Instructions on Reverse Side



R W 0 1

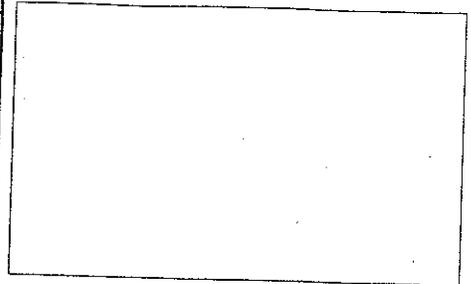
DO NOT USE THIS SPACE

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)

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SOCIAL SECURITY NUMBER 605240354		DATE OF INJURY 12-22-07	
EMPLOYEE Kathy Topete		Date of Birth 11-3-81	
EMPLOYER CMG			
INSURER/SELF-INSURER/TPA			
INSURER CLAIM NUMBER			



Date of most recent examination by this office **1-10-08** (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 **1-10-08** to **12-26-07** (date) to _____ (date)

The next scheduled visit is: as needed OR _____ (date)

2 wks

NAME	SIGNATURE <i>Larry D Christensen</i>		DEGREE MD
ADDR	STATE	LICENSE #/REGISTRATION #	
CITY	AREA CODE	TELEPHONE #	DATE SIGNED 1-10-08

LARRY D CHRISTENSEN, MD PIPESTONE FAMILY CLINIC
920 4TH AVE SW PIPESTONE, MN 56164
507-825-5700 EXT. 4771 FAX 507-825-4763
DEA-AC7916539 MN LTSC-23799 UPIN D75623

Report of Work Ability

See Instructions on Reverse Side



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

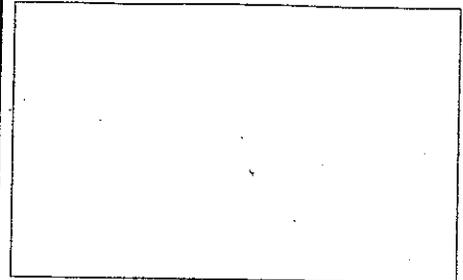
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(Minn. Rules 5221.0410, subp. 6)

RW01

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SOCIAL SECURITY NUMBER 605 240 354	DATE OF INJURY 12-22-07
EMPLOYEE Kathy Topete	Date of Birth 11-3-81
EMPLOYER Surdon	
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)

1 week

NAME	SIGNATURE <i>Larry D Christensen</i>		DEGREE MD
ADDR LARRY D CHRISTENSEN, MD PIPESTONE FAMILY CLINIC 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 EXT. 4771 FAX 507-825-4763 DEA-AC7916539 MN LISC-23799 UPIN D75623	STATE	LICENSE #/REGISTRATION #	
CITY	AREA CODE	TELEPHONE #	DATE SIGNED 1-3-2008