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 X 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
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 "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 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 Tram 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 ☒	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.) 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 Nereido Topete **Date of Injury:** 12/22/07

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 N 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

Treatment Plan: Knee Brace

____ **Non-work related**

____ **Undetermined**

__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.)

__X__ **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] MD **Date:** 12/26/07

Please fax back to 507.562.6800 – Attn CMG.

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
605240354	~~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)	SIGNATURE	DEGREE
ADDRESS: LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP 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

MN RW01 (7/01)

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 # 605-24-0354	2. OSHA Case #						
3. DATE OF CLAIMED INJURY 12/24/2007	4. Time of injury 08:50 ☑ am ☐ pm	5. Time employee began work on date of injury 07:00 ☑ am ☐ pm					
6. EMPLOYEE Name (last, first, middle) Topete Kathy		7. Gender ☐ M ☑ F	8. Marital Status ☑ Married ☐ 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 ☑ Full time ☐ Seasonal	☐ Part time ☐ Volunteer		
20. Weekly value of: Meals	Lodging	2nd income	21. Apprentice ☐ 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."*

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? ☑ Yes ☐ 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) ☐ Yes ☑ No ☐ 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 ☐ Yes ☑ No 35. Overnight in-patient ☐ Yes ☑ 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) Berkley Risk Administrators Company, LLC	Insurer 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)

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 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 ☑	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.) 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

BRAC 2520 (10/99)

Report of Work Ability

See Instructions on Reverse Side

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)

RW01

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SOCIAL SECURITY NUMBER	DATE OF INJURY
605240354	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 / 12-26-07 (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____ (date) 2 wks

NAME	SIGNATURE	DEGREE
ADDRESS: 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 1-10-08

MN RW01 (7/01)

Report of Work Ability

See Instructions on Reverse Side

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)

RW01

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SOCIAL SECURITY NUMBER	DATE OF INJURY
605 240 354	12-22-07
EMPLOYEE: Kathy Topete	Date of Birth: 11-3-81
EMPLOYER: Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 1-3-08 (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 1-3-08 (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____ (date) 1 week

NAME	SIGNATURE	DEGREE
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 E	AREA CODE / TELEPHONE #	DATE SIGNED: 1-3-2008

MN RW01 (7/01)