

# Report of Work Ability

See Instructions on Reverse Side



R W 0 1

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)

DO NOT USE THIS SPACE

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 479 08 5820	DATE OF INJURY 12-3-07
EMPLOYEE Kim Hunt	Date of Birth 9-15-73
EMPLOYER CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 12-10-07 (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 12-10-07 (date) to \_\_\_\_\_ (date)

The restrictions are:

Avoid activity that causes left index finger pain

3.  Employee is unable to work at all, from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

The next scheduled visit is:  as needed OR \_\_\_\_\_ (date) 4 wks

NAME (Type or Print)	SIGNATURE <i>L.D. Christensen</i>	DEGREE MD	
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 12/10/07



# 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 return to work. No employee will be allowed to return to work without a satisfactory Fitness for Duty Certification on file.

Employee Name: Kim Hunt Date: 12/03/07

Is employee able to perform the functions of his/her position?  Yes  No unknown

Any restrictions?  Yes  No If yes, please describe restriction(s) and duration below:

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: \_\_\_\_\_ 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: Avoid activity that causes lt. index finger pain

Next Appt. Date / Time: 4 wks Provider's Comments: \_\_\_\_\_

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

Physician or Practitioner Signature: [Signature]

Type of Practice: (Field of Specialization) Family Practice

12/11/2007  
9:34:35AM

# Timesheet

143

Date Range: 11/25/2007 - 12/08/2007

*Rue Simpson*

<b>Name:</b> Hunt, Kimberly	<b>Home Account:</b> 2/160/104
<b>Number:</b> 15	<b>Badge Number:</b> 62

Punch Date	In	Account	Out	Hours	Daily	Pay Period
Pay Period Start: 11/25/2007 Sunday						
11/26/2007	Mon	2/160/104	6:56 AM	3:32 PM	8:00	8:00
11/27/2007	Tue	2/160/104	6:48 AM	3:28 PM	8:15	8:15
11/28/2007	Wed	2/160/104	6:49 AM	3:31 PM	8:15	8:15
11/29/2007	Thu	2/160/104	6:50 AM	3:28 PM	8:15	8:15
11/30/2007	Fri	2/160/104	6:43 AM	3:34 PM	8:15	8:15
12/3/2007	Mon	2/160/104	6:46 AM	11:00 AM	4:15	4:15
12/6/2007	Thu	2/160/104	6:51 AM	8:23 AM	1:45	1:45
12/8/2007	Sat	2/160/104	6:42 AM	3:32 PM	8:15	8:15

Effective Date/Time	Account	Pay Code	Duration	Dollars
12/04/07 12:00 am	2/160/104	Sick	8:00	\$0.00
12/05/07 12:00 am	2/160/104	Work Comp	8:00	\$0.00

Account	Pay Code	Duration	Dollars
2/160/104	Overtime	1:00	\$0.00
2/160/104	Regular	54:15	\$0.00
2/160/104	Sick	8:00	\$0.00
2/160/104	Work Comp	8:00	\$0.00
		<u>71:15</u>	<u>0.00</u>

Pay Code	Duration	Dollars
Overtime	1:00	\$0.00
Regular	54:15	\$0.00
Sick	8:00	\$0.00
Work Comp	8:00	\$0.00
	<u>71:15</u>	<u>0.00</u>

<b>Name:</b> Hunt, Wendell	<b>Home Account:</b> 1/162/104
<b>Number:</b> 1389	<b>Badge Number:</b> 927

Punch Date	In	Account	Out	Hours	Daily	Pay Period
Pay Period Start: 11/25/2007 Sunday						
11/26/2007	Mon	1/162/104	7:04 AM	3:34 PM	8:00	8:00

Effective Date/Time	Account	Pay Code	Duration	Dollars
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# Timesheet

Date Range: 11/25/2007 - 12/08/2007

## Employee Totals By Account

Account	Pay Code	Duration	Dollars
1/162/104	Regular	8:00	\$0.00
		8:00	0.00

## Employee Totals

Pay Code	Duration	Dollars
Regular	8:00	\$0.00
	8:00	0.00

Name: Hurley, Danielle

Home Account: 2/163/104

Number: 1640

Badge Number: 1640

Punch Date In Account Out Hours Daily Pay Period

Pay Period Start: 11/25/2007 Sunday

11/26/2007	Mon	6:51 AM	4/163/104	3:34 PM	8:15	8:15	8:15
11/27/2007	Tue	6:59 AM	4/163/104	3:38 PM	8:15	8:15	16:30
11/29/2007	Thu	6:49 AM	4/163/104	3:35 PM	8:15	8:15	24:45
11/30/2007	Fri	6:47 AM	4/163/104	3:35 PM	8:15	8:15	33:00
12/3/2007	Mon	6:52 AM	2/163/104	12:10 PM	5:30	5:30	38:30
12/5/2007	Wed	6:49 AM	2/163/104	3:38 PM	8:30	8:30	47:00
12/6/2007	Thu	7:00 AM	2/163/104	3:40 PM	8:15	8:15	55:15
12/7/2007	Fri	6:49 AM	2/163/104	3:37 PM	8:15	8:15	63:30

## Employee Pay Code Edits

Effective Date	Time	Account	Pay Code	Duration	Dollars
11/28/07	12:00 am	4/163/104	Personal Time	8:00	\$0.00
12/03/07	12:00 am	2/163/104	Sick	8:00	\$0.00

## Employee Totals By Account

Account	Pay Code	Duration	Dollars
2/163/104	Regular	30:30	\$0.00
2/163/104	Sick	8:00	\$0.00
4/163/104	Personal Time	8:00	\$0.00
4/163/104	Regular	33:00	\$0.00
		79:30	0.00

## Employee Totals

Pay Code	Duration	Dollars
Personal Time	8:00	\$0.00
Regular	63:30	\$0.00
Sick	8:00	\$0.00
	79:30	0.00

# 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 # 479-08-5820		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 11/13/2007		4. Time of injury 10:00 <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) Hunt Kimberly		7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried
9. Home address 1125 E. 9th Ave.		10. Home phone # (507) 727-1083	11. Date of birth 9/15/1973
City Worthington	State MN	Zip Code 56187	12. Occupation Production Teammat
13. Regular department Material Prep.		14. Date hired 9/10/2007	
15. Average weekly wage	16. Rate per hour \$10.00	17. Hours per day 8	18. Days per week 5
19. Employment Status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer		21. Apprentice <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
20. Weekly value of: Meals	Lodging	2 <sup>nd</sup> income	21. Apprentice
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."  Seizure			
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. Seizure		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. n/A	
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 type="checkbox"/> No <input checked="" type="checkbox"/> No lost time on DOI
		28. Date employer notified of injury 11/13/2007	29. Date employer notified of lost time
		30. Return to work date	31. Date of death
32. TREATING PHYSICIAN (name, address, and phone) N/A N/A Pipestone MN 56164 (507) 825-5700		33. HOSPITAL/CLINIC (name and address) (if any) Pipestone Medical Group 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 # Jessica Fraser (507) 562-6713
42. Physical address (if different)		43. Witness (name and phone) N/A at this time	
City	State	Zip Code	44. NAICS code
		45. Date form completed 11/13/2007	
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 11/13/2007	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 "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 Kimberly Hunt COMPANY CORPORATE MANAGEM DEPT. Material Prep.  
DATE OF ACCIDENT 11/13/2007 TIME 10:00 AM DID EMPLOYEE LOSE TIME FROM WORK? YES  NO   
HOURS LOST ON DATE OF ACCIDENT 5 HAS EMPLOYEE RETURNED TO WORK? YES  NO   
JOB TITLE Production Teammat 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.) Seizure

WITNESSES' NAMES N/A at this time

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 N/A DATE OF INITIAL VISIT \_\_\_\_\_  
ADDRESS N/A, 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 She noted she has a history of siezures.

REPORT SUBMITTED BY Mike Petronek  
(507) 562-6713

DATE 11/13/2007

# 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 # 479-08-5820		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 12/3/2007		4. Time of injury 08:45 <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) Hunt Kimberly		7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried
9. Home address 1125 East 9th Ave		10. Home phone # (507) 727-1083	11. Date of birth 9/15/1973
City Worthington	State MN	Zip Code 56187	12. Occupation laborer
13. Regular department Material Preparation		14. Date hired 9/10/2007	
15. Average weekly wage \$400.00	16. Rate per hour \$10.00	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 \$0.00 Lodging \$0.00	2 <sup>nd</sup> 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." cut finger on saw blade			
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. cut hand on pointer finger		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. saw blade	
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 Corp Pipestone MN 56164		26. Date of first day of any lost time 12/3/2007	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 12/3/2007	29. Date employer notified of lost time 12/3/2007
		30. Return to work date 12/5/2007	31. Date of death
32. TREATING PHYSICIAN (name, address, and phone) Pipestone CT medical Center 481 4th Street Pipestone MN 56164 (507) 825-5811		33. HOSPITAL/CLINIC (name and address) (if any) Pipestone County Medical Center 481 4th Street 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 # Eileen M. Stephenson (507) 562-6808
42. Physical address (if different)		43. Witness (name and phone) Keith Swenson (507) 562-4013	
City	State	Zip Code	44. NAICS code
		45. Date form completed 12/03/2007	
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 12/03/2007	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 Kimberly Hunt COMPANY CORPORATE MANAGEM DEPT. Material Preparation  
DATE OF ACCIDENT 12/3/2007 TIME 8:45 AM DID EMPLOYEE LOSE TIME FROM WORK? YES  NO   
HOURS LOST ON DATE OF ACCIDENT 6.5 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"/>  |
| 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.) cut finger on saw blade

WITNESSES' NAMES Keith Swenson

**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 Pipestone CT medical Center DATE OF INITIAL VISIT \_\_\_\_\_  
ADDRESS 481 4th STreet, Pipestone, MN 56164 TELEPHONE NUMBER (507) 825-5811

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

REASONS WHY \_\_\_\_\_

REPORT SUBMITTED BY Mike Petronek DATE 12/03/2007  
(507) 562-6791

CMG  
~~ESSG~~ Medical Referral to Employer

Employee Name: Kim Hunt Date of Injury: 12/03/07

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.

Kimberly Hunt  
Employee Signature Date 12/03/07

Medical Provider Pipestone, MN 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:

CMG  
~~ESSG~~  
7300 Metro Blvd  
Ste. 635  
Edina, MN 55439  
(952)835-1288  
Ex: (952)835-1255

Berkley Risk  
FILED

Diagnosis: Cut hand on - pointer finger  Non-work related  
saw (blade) 4 stitches  Undetermined  
Treatment Plan: Dressing / Splint  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: 12-3-07 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: [Signature] Date: 12-3-07

Pipestone County Medical Ctr

Pipestone, MN 507-825-5811

HUNT, KIMBERLEY  
ACCT#: H0244021 MR#: H046644  
ER 09/15/73 34 F  
12/03/07 CHRISTENSEN, LARRY D.

Discharge Date 12/03/07 Time: 1007

DIAGNOSIS: laceration to left index finger  
DIAGNOSIS: fracture to tip of finger left index

DIET: regular  
Activity no work for 36 hours

Medication, Dose, When to take it, Why you take it  
: Tylenol for pain

Physician orders/Special instructions:  
: \*\*\* ER - Wound Care \*\*\*  
: 1. Keep involved area clean and dry. Keep cover if draining.  
: 2. Keep covered with a original dressing for 36 hours.  
: 3. Keep open to air if not draining and can be kept clean.  
: 4. Report signs of infection: redness and pain, swelling,  
: drainage, and/or fever.  
: 5. After 24 hours, may gently wash.  
: 6. Wear splint at all times until seen by Dr christensen.

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

Return Appointments:  
: Dr Christensen mon Dec 10 @ 4:00

Discharge to Home/Self care  
Accompanied by Self per Ambulatory  
T 97.8 P 88 R 20 B/P 135/92 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 12/03/07 at 1019

**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 # 479-08-5820		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 12/3/2007		4. Time of injury 08:45 <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) Hunt Kimberly		7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried
9. Home address 1125 East 9th Ave		10. Home phone # (507) 727-1083	11. Date of birth 9/15/1973
City Worthington	State MN	Zip Code 56187	12. Occupation laborer
13. Regular department Material Preparation		14. Date hired 9/10/2007	
15. Average weekly wage \$400.00	16. Rate per hour \$10.00	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 \$0.00 Lodging \$0.00 2 <sup>nd</sup> 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." cut finger on saw blade	
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 cut hand on pointer finger		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard saw blade	
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 Corp Pipestone MN 56164		26. Date of first day of any lost time 12/3/2007	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 12/3/2007		29. Date employer notified of lost time 12/3/2007	
30. Return to work date 12/5/2007		31. Date of death	
32. TREATING PHYSICIAN (name, address, and phone) Pipestone CT medical Center 481 4th Street Pipestone MN 56164 (507) 825-5811		33. HOSPITAL/CLINIC (name and address) (if any). Pipestone County Medical Center 481 4th Street 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 # Eileen M. Stephenson (507) 562-6808
42. Physical address (if different)		43. Witness (name and phone) Keith Swenson (507) 562-4013	
City	State	Zip Code	44. NAICS code
		45. Date form completed 12/03/2007	
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 12/03/2007	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 Kimberly Hunt COMPANY CORPORATE MANAGEM DEPT. Material Preparation  
DATE OF ACCIDENT 12/3/2007 TIME 8:45 AM DID EMPLOYEE LOSE TIME FROM WORK? YES  NO   
HOURS LOST ON DATE OF ACCIDENT 6.5 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"/>  |
| 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.) cut finger on saw blade

WITNESSES' NAMES Keith Swenson

**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 Pipestone CT medical Center DATE OF INITIAL VISIT 12/03/2007  
ADDRESS 481 4th STreet, Pipestone, MN 56164 TELEPHONE NUMBER (507) 825-5811

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

REASONS WHY

REPORT SUBMITTED BY Mike Petronek  
(507) 562-6791

DATE 12/03/2007

3 PART DRUGS OF ABUSE TEST REQUEST



SPECIMEN ID 48521898

Employer: SUZLON ROTOR CORPORATION  
1711 S HWY 75  
PIPESTONE, MN 56164



MRO:

Account # 93470

Test(s) Ordered  88543



1 To be completed by COLLECTOR / DONOR

Donor I.D. 479-08-5820 Social Security No, Employee No. or other Identification No. Specimen Type:  Blood  Urine  Oral Fluid  
Donor Name (last, first) or SSN Hunt, Kimberly  
Donor Daytime Phone 507-255-5508 Referring Phys. / Company SLM

DONOR CONSENT I certify that I provided my specimen to the collector, that the specimen container was sealed with a tamper-proof seal in my presence, and that the information provided on this form and on the label affixed to the specimen bottle is correct. I authorize MEDTOX to release the results of the tests to my employer, prospective employer, employer representative and/or their authorized healthcare professionals.

Signature Kimberly Hunt DATE 12-03-2007

2 To be Completed by COLLECTOR

Indicate Reason for Test  Pre-employment  Random  Reasonable Suspicion  Other (specify):  Return to Duty  Follow-up  Post Accident  Periodic Medical

3 To be Completed by COLLECTOR

Specimen temperature must be read within 4 minutes of collection Specimen Temperature within range: (90°-100°F/32°-38°C) 81605  YES  No, Remark Required

4 To be Completed by COLLECTOR

Collection Site Location: Facility and Address PIPESTONE COUNTY MED CENTER  
PIPESTONE, MN 56164

Collection Site Phone No. (507) 825-5811 Fax No. (507) 825-6081

Date and Time of Collection 12-03-2007 11:025 am

Remarks Concerning Collection

I, the collector, by signing below certify that the specimen identified on this form is the specimen given to me by the donor identified above and that it has been collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X [Signature] Signature of Collector  
Tanya L. Fee (PRINT) Collector's Name (First, MI, Last)

SPECIMEN BOTTLE(S) RELEASED TO:

Name of Delivery Service Transferring Specimen to Lab  DHL  Local Courier  Other

5

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 # 479-08-5820		2. OSHA Case #		DO NOT USE THIS SPACE			
3. DATE OF CLAIMED INJURY 11/13/2007		4. Time of injury 10:00 <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) Hunt Kimberly			7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried		
9. Home address 1125 E. 9th Ave.			10. Home phone # (507) 727-1083		11. Date of birth 9/15/1973		
City Worthington		State MN		Zip Code 56187		12. Occupation Production Teammt	
13. Regular department Material Prep.			14. Date hired 9/10/2007				
15. Average weekly wage		16. Rate per hour \$10.00		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. 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." Seizure							
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. Seizure				24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. n/A			
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 type="checkbox"/> No <input checked="" type="checkbox"/> No lost time on DOI			
		28. Date employer notified of injury 11/13/2007		29. Date employer notified of lost time			
		30. Return to work date		31. Date of death			
32. TREATING PHYSICIAN (name, address, and phone) N/A N/A Pipestone MN 56164 (507) 825-5700			33. HOSPITAL/CLINIC (name and address) (if any) Pipestone Medical Group 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 # 003673110	
City THORNTON		State CO		Zip Code 80241		41. Employer's contact name and phone # Jessica Fraser (507) 562-6713	
42. Physical address (if different)				43. Witness (name and phone) N/A at this time			
City		State		Zip Code		44. NAICS code	
						45. Date form completed 11/13/2007	
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 11/13/2007		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 Kimberly Hunt COMPANY CORPORATE MANAGEM DEPT. Material Prep.  
 DATE OF ACCIDENT 11/13/2007 TIME 10:00 AM DID EMPLOYEE LOSE TIME FROM WORK? YES  NO   
 HOURS LOST ON DATE OF ACCIDENT 5 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 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.) Seizure

WITNESSES' NAMES N/A at this time

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 N/A DATE OF INITIAL VISIT 11/13/2007  
 ADDRESS N/A, 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 She noted she has a history of siezures.

REPORT SUBMITTED BY Mike Petronek DATE 11/13/2007  
(507) 562-6713

NOV, 13 2007

ME AND KIMBERLY WERE PUSHING A ROLL CART DOWN THE TABLE, WHEN KIMBERLY GOT DOWN TO THE END OF THE TABLE SHE WENT DOWN ON ONE KNEE I MOVED OVER TO SEE IF SHE WAS AIRIGHT AND COULD TELL SHE WASN'T, I GRABBED KIM BY THE SIDE AND LAYED HER DOWN SO SHE WOULD NOT HIT HER HEAD. AT THIS TIME KIMBERLY WENT INTO A SEIZURE, I THEN GOT HELP TO HER. VIOLA CAME AND GAVE HER MOUTH TO MOUTH BECAUSE KIMBERLY WAS HAVING TROUBLE BREATHING. WE CALLED FOR A AMBUANCE.

Todd Blare

Todd Blare



SUZLON



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

# Suzlon Accident Report

Team Member: Kimberly Hunt  
~~Debra Hunt~~

Taken to Hospital or Clinic? Y  N

Date of Occurrence: 11-13-07

Is This a Near Miss? Y  N

Time of Occurrence: 10:15

Date Reported: 11-13-07

Team Leader: Keith O. Swenson

Department: Material Prep

Day shift  Night shift

Location of where accident occurred (be specific)

TABLE #

COPY

Description of accident / injury

Pushing a roll cart down AISLE, when we got to the end of the table Kimberly went down on one knee I asked her if she was alright and she had NO

→ over

Witnesses names

TODD BLORE

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

Employee Feedback

Team Member Signature

Keith O Swenson

Date

11-13-07

Team Leader Signature

[Signature]

Date

13-NOV-07

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*



# Suzlon Accident Report

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

Team Member: Kimberly Hunt

Taken to Hospital or Clinic? Y  N

Date of Occurrence: 11-13-07

Is This a Near Miss? Y  N

Time of Occurrence: 10:15

Date Reported: 11-13-07

Team Leader: Keith O Swenson

Department: Material Prep

Day shift  Night shift

Location of where accident occurred (be specific)

TABLE #

Description of accident / injury

Pushing roll cart down AISLE, when we got to the end of the table Kimberly went down on one knee I asked her if she was alright and she had NO → OVER

Witnesses names

TODD BLORE

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

Employee Feedback

Team Member Signature

Date

Keith O Swenson

11-13-07

Team Leader Signature

Date

[Signature]

13-NOV-07

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*



Jessica Fraser  
Account Manager  
Phone: 507.562.6713  
Fax: 507.562.6800  
jessica@corpmgmtgroup.com

# Fax

<b>To:</b> CMG Corp/ESSG	<b>From:</b> Jessica
<b>Fax:</b>	<b>Pages:</b>
<b>Phone:</b>	<b>Date:</b> 10/03/2007
<b>Re:</b>	<b>CC:</b>

**Urgent**     **For Review**     **Please Comment**     **Please Reply**     **Please Recycle**

● **Comments:**

ESSG Please file with Work Comp.

**Kimberly Hunt**

Date of Injury: 10.03.07  
Treatment: 10.03.07  
Medical Only; prescription given; NO restrictions

Treatment at the Pipestone Co. Medical Group  
Dr. Cooper  
825.5700

3 PART DRUGS OF ABUSE TEST REQUEST



SPECIMEN ID U8448834

Employer: SUZLON ROTOR CORPORATION  
1711 S HWY 75  
PIPESTONE, MN 56164

MRO:

Account # 93470

Test(s) Ordered

68543



STEP 1

To be completed by COLLECTOR / DONOR

Donor I.D. 479-08-5820  
Donor Name (last, first) or SSN: Hunt, Kimberley  
Donor Daytime Phone: 5077271083  
Social Security No, Employee No. or other Identification No.  
Specimen Type:  Blood  Urine  Oral Fluid  
Referring Phys./Company: Suzlon

DONOR CONSENT I certify that I provided my specimen to the collector, that the specimen container was sealed with a tamper-proof seal in my presence, and that the information provided on this form and on the label affixed to the specimen bottle is correct. I authorize MEDTOX to release the results of the tests to my employer, prospective employer, employer representative and/or their authorized healthcare professionals.

Signature: Kimberley Hunt  
DATE: 10-23-2007

STEP 2

To be Completed by COLLECTOR

Indicate Reason for Test:  Pre-employment  Random  Reasonable Suspicion  Other (specify):  
 Return to Duty  Follow-up  Post Accident  Periodic Medical

STEP 3

To be Completed by COLLECTOR

Specimen temperature must be read within 4 minutes of collection:  YES  No, Remark Required  
Specimen Temperature within range: (90°-100°F/32°-38°C)  
81605

STEP 4

To be Completed by COLLECTOR

Collection Site Location: Facility and Address 451  
PIPESTONE COUNTY MED CENTER  
PIPESTONE, MN 56164

Collection Site Phone No. (507) 825-5811  
Fax No. (507) 825-6081

Date and Time of Collection: 10-23-2007 10:20 am

Remarks Concerning Collection

I, the collector, by signing below certify that the specimen identified on this form is the specimen given to me by the donor identified above and that it has been collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

Signature of Collector: Kimberley Hunt  
(PRINT) Collector's Name (First, MI, Last): Kimberley L. Hunt

SPECIMEN BOTTLE(S) RELEASED TO:  
Name of Delivery Service Transferring Specimen to Lab:  DHL  Local Courier  Other

STEP 5

Copyright Medtox 1999



Jessica Fraser  
Account Manager  
Phone: 507.562.6713  
Fax: 507.562.6800  
jessica@corpmgmtgroup.com

# Fax

<b>To:</b> CMG Corp/ESSG	<b>From:</b> Jessica
<b>Fax:</b>	<b>Pages:</b>
<b>Phone:</b>	<b>Date:</b> 10/03/2007
<b>Re:</b>	<b>CC:</b>

**Urgent**     **For Review**     **Please Comment**     **Please Reply**     **Please Recycle**

● **Comments:**

ESSG Please file with Work Comp.

**Kimberly Hunt**

Date of Injury: 10.03.07  
Treatment: 10.03.07  
Medical Only; prescription given; NO restrictions

Treatment at the Pipestone Co. Medical Group  
Dr. Cooper  
#507.825.5700



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

# Suzlon Injury Report

Team Member: Kim Hunt

Date of Occurrence: 3 Oct 2007

Time of Occurrence: 1030

Department: Material Prep

Team Leader: Viola Foster

Date Reported: 3 Oct 2007

If taken to Doctor, fill out this section

Date of Treatment: \_\_\_\_\_

Time of Treatment: \_\_\_\_\_

Doctor: \_\_\_\_\_

Drug Test Performed: Yes No

Drug test date & time: \_\_\_\_\_

Location of where accident occurred (be specific)

Table 3 in material prep area

Description of accident / injury

Cutting CFM glass face became itchy red and swollen. Very painful

Witnesses names

Lisa Olsen, Sandra Rothmeier

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

Face mask mandatory in Mat Prep

Employee Feedback

Team Member Signature

Viola Foster

Team Leader Signature

Janice Brown

Human Resources Signature

Date

3 Oct 2007

Date

3-Oct-2007

Date

**COPY**



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



## 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 SRC 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 Suzlon 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 SRC 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 Minnesota 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.

Date: 10-3-07



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

# Referral for Medical Treatment Report to Employer

Employee Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**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:

**AIG**  
PO Box 1822  
Alpharetta, GA 30023  
1-866-642-5246

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

Diagnosis: Fiberglass laceration \_\_\_\_\_ Non-work related  
\_\_\_\_\_ Undetermined

Treatment Plan: Elson WRM \_\_\_\_\_  Work related

**RETURN TO WORK:**  With No Limitations Date: 10-3-07  
(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: as needed Provider's Comments: \_\_\_\_\_  
May use Bradley 25mg 9-6 hrs prn pruritis  
\_\_\_\_\_ itching

Medical Provider Signature: \_\_\_\_\_ Date: 10-3-07

10/25

22324



**AIG Domestic Claims, Inc.**  
Workers' Compensation Division

P. O Box 1821  
Alpharetta, GA 30023-1821  
866-642-5246 (Toll Free)  
866-958-1211 (Fax)

Oct 23, 2007

PIPESTONE MEDICAL GROUP  
920 4<sup>TH</sup> AVENUE SW  
PIPESTONE MN 56164

To whom it may concern:

We are unable to process the enclosed documentation for the following reason(s):

- Our records indicate that an Employer's First Report of Injury has not been received for this employee. If the report has already been sent, we would appreciate your forwarding another copy with the enclosed documentation. A new Workers' Compensation injury can also be reported by phone at **(877) 399-6442**.
- We have researched the attached documents but have been unable to match the patient to a claim in our Workers' Compensation data base. Please verify this is a Workers' Compensation claim and that AIG is the handling administrator of these claims.
- We need additional information to process (checked):
 

<input type="checkbox"/> AIG CLAIM NUMBER	<input type="checkbox"/> AIG POLICY NUMBER	<input type="checkbox"/> TAX ID NUMBER
<input type="checkbox"/> CLAIMANT NAME	<input type="checkbox"/> INSURED NAME	<input type="checkbox"/> ITEMIZED CHARGES
<input type="checkbox"/> SS NUMBER	<input type="checkbox"/> DATE OF INJURY/LOSS	<input type="checkbox"/> CPT/REV CODES
<input type="checkbox"/> DATE OF BIRTH	<input type="checkbox"/> DATE OF SERVICE	<input type="checkbox"/> PROVIDER NAME PHYSICAL ADDRESS
- Additionally several states require the use of standard HCFA/CMS1500 or UB92/UB04 billing form. AR, CO, CT, DC, FL, KS, LA, MA, MI, MN, MS, NC, NH, NM, NV, PA, RI, SD, TX, & VT
- Other: Our records indicate that your company is the designated TPA for this policy. Please notify the sender of your correct mailing address.

Please resubmit all documentation with the information requested should additional processing be necessary. **If you have any questions on this correspondence, please contact our Customer Service Department at 866-642-5246.** Thank you for your cooperation.

AIG Domestic Claims, Inc.  
Document Management Center  
Linda Lafond, Manager (R 27)

ENCL: Original Correspondence

ALP DP41 OCT 16 2007

AIG  
PO BOX 1825

0100

1500

HEALTH INSURANCE CLAIM FORM

ALPHARETTA

GA 30023

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 479085820
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HUNT KIM K		3. PATIENT'S BIRTH DATE MM DD YY 09 15 1973 M <input type="checkbox"/> F <input checked="" type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) 1125 E 9TH AVE CITY: WORTHINGTON STATE: MN ZIP CODE: 56187 TELEPHONE (Include Area Code): (507) 727 1083		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HUNT KIM K
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 1125 E 9TH AVE CITY: WORTHINGTON STATE: MN ZIP CODE: 56187 TELEPHONE (Include Area Code): (507) 727 1083
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYER'S NAME OR SCHOOL NAME SUZLON ROTOR CORPORATION
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME AIG
c. EMPLOYER'S NAME OR SCHOOL NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # yes, return to and complete item 9 a-d
d. INSURANCE PLAN NAME OR PROGRAM NAME NO OTHER COVERAGE		10d. RESERVED FOR LOCAL USE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  
SIGNATURE ON FILE 100907  
SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  
SIGNATURE ON FILE  
SIGNED \_\_\_\_\_

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 10 03 07	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE GREG A COOPER MD	17a. IG D80008 17b. NPI 1730179870	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Re/ate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 692.9	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO
2. _____	23. PRIOR AUTHORIZATION NUMBER

A	DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ESSENTIAL Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
	From MM DD YY	To MM DD YY									
1	10	03	11		99202	1	95 00	1		NPI	1730179870
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER 411831345	SSN EIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO 73880021	27. ACCEPT ASSIGNMENT? (For gov. claims see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 95 00	29. AMOUNT PAID \$ 0 00	30. BALANCE DUE \$ 95 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) D80008 GREG A COOPER MD SIGNED 100907 DATE		32. SERVICE FACILITY LOCATION INFORMATION PIPESTONE MEDICAL GROUP 920 4TH AVE SW PIPESTONE MN 56164 a. 1073576906 b.		33. BILLING PROVIDER INFO & PH # (507) 825 5700 PIPESTONE MEDICAL GROUP 920 4TH AVENUE SW PIPESTONE MN 56164 a. 1730179870 b.		

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

RETURN TO PROVIDER

780-0116 (08-05) (OCR) 1PT.

# 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)

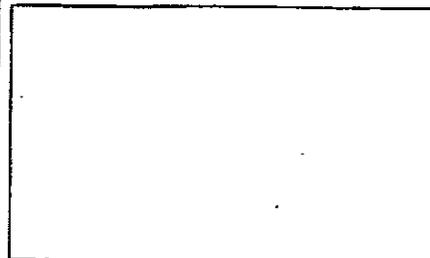
ALP DP41 OCT 16 2007

RW01

DO NOT USE THIS SPACE

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 479 08 5820	DATE OF INJURY 10-3-07
EMPLOYEE Kim Hunt	Date of Birth 9-15-73
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:

POOR IMAGE QUALITY

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) Dr Greg Cooper	SIGNATURE 	DEGREE MD
ADDRESS 920 4th Ave SW	STATE MN	LICENSE #/REGISTRATION # 30422
CITY Pipestone, MN	STATE MN	ZIP CODE 56164
CITY Pipestone, MN	AREA CODE 506	TELEPHONE # 525-5700
CITY Pipestone, MN	STATE MN	DATE SIGNED 10-3-07

# Health Care Provider Report

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

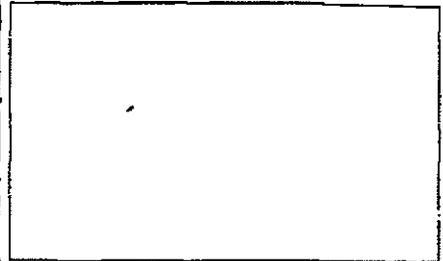


H C 0 1

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

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER <b>479 08 5820</b>	DATE OF INJURY <b>10-3-07</b>	DOB <b>9-15-73</b>
EMPLOYEE <b>Kim Hunt</b>	EMPLOYER <b>Suzlon</b>	
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: **10-3-07** (date)
2. Diagnosis (include all ICD-9-CM codes):  
**fiberglass dermatitis**
3. History of injury or disease given by employee:  
**WWD cleaning fiberglass white @ work @ Suzlon**
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: \_\_\_\_\_ (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 (Type or Print) <b>Dr. Greg Cooper</b>	SIGNATURE 	DEGREE <b>M.D.</b>
ADDRESS <b>9200 4th Ave SW</b>	STATE <b>Mn.</b>	LICENSE #/REGISTRATION # <b>30422</b>
CITY <b>Pipestone</b>	STATE <b>Mn.</b>	ZIP CODE <b>56164</b>
AREA CODE <b>564</b>	TELEPHONE # <b>825-5700</b>	DATE SIGNED <b>10-3-07</b>

PIPESTONE MEDICAL GROUP  
920 4TH AVENUE SW  
PIPESTONE, MN 56164-1455

*As a regional network of persons and institutions, Avera Health clinics are dedicated to the patients we serve. It is our mission to deliver excellence in patient care to all surrounding communities.*



ADDRESS SERVICE REQUESTED

Statement Date: 11/13/07  
Account Number: WC151735

001683 002 TH15 BNS D3Q9 5000 P 4807E

KIM K HUNT  
1125 E 9TH AVE  
WORTHINGTON, MN 56187-2237

PIPESTONE MEDICAL GROUP  
920 4TH AVENUE SW  
PIPESTONE, MN 56164-1455



**Amount Due: \$0.00**

Please detach and return top portion with your payment. See back for credit card payment options.

## Summary of Services

\$95.00	Unpaid Balance
- \$95.00	Awaiting Insurance Response
<b>\$0.00</b>	<b>Due from Patient</b>



### For Patient Services Regarding:

- Status of an Insurance Claim
- Assistance with a Denial
- Assistance with Amount Due
- Address or Insurance Changes
- General Assistance

### Please Contact Us...We Are Here to Help:

Monday-Friday: 8:00 a.m. - 5:00 p.m.  
 Phone Number: 507-825-5700  
 Toll Free: 800-332-1155  
 Fax Number: 507-825-4752

PIPESTONE MEDICAL GROUP  
 920 4TH AVENUE SW  
 PIPESTONE, MN 56164-1455

A finance charge of 1.5% will be applied to any patient balance over 60 days old.



ADDRESS SERVICE REQUESTED

001683 002 TH15 BNS D3Q9 5000 P 4807E  
 Statement Date: 11/13/07  
 Responsible Party: KIM K HUNT  
 Account Number: WC151735

### DETAIL OF SERVICES

Date	Explanation of Activity	Charges	Payments	Awaiting Insurance Response	Due From Patient
Visit 7388002 for KIM K HUNT on 10/03/2007					
10/03/07	99202 Office Visit Level 2	\$95.00		\$95.00	
10/09/07	SENT TO WORKMANS COMP				
	***** VISIT TOTALS:	\$95.00		\$95.00	
Statement Totals		\$95.00		\$95.00	

PIPESTONE MEDICAL GROUP HAS  
 SATELLITE LOCATIONS AT  
 JASPER FAMILY AND EDGERTON  
 FAMILY CLINICS

PLEASE SPECIFY DATES OF SERVICE BEING PAID. PYMNTS  
 NOT SPECIFIED WILL BE APPLIED TO OLDEST BALANCE.

Unpaid Balance: \$95.00  
 Awaiting Insurance Response: \$95.00  
 Due from Patient: \$0.00

