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

Suzlon Injury Report

Team Member: Larry Mohr

Date of Occurrence: 5-23-08

Time of Occurrence: after 200 pm break

Department: Finishing

Team Leader: Scott B

Date Reported: 5-24-08

If taken to Doctor, fill out this section

Date of Treatment: 5-24-08

Time of Treatment: 8 00 Am

Doctor:

Drug Test Performed: (Yes) No

Drug test date & time: 900 Am

Location of where accident occurred (*be specific*)

Red & white line wet layup

Description of accident / injury

Left eye got resin in eye by accidently rubbing eye

Witnesses names

none

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

don't touch eyes with dirty hands

wear goggles

Employee Feedback

didn't believe he got resin in at that time

Team Member Signature

Larry G. Mohr

Date

6-12-08

Manager Signature

Date

Human Resources Signature

Date

RECEIVED
JUN 18 2008
BY:

F:SF:03 Rev Num:1 Rev Date: 23-AUG-2006

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: Larry Mohr Date: _____

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

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

RETURN TO WORK: _X_ With No Limitations Date: 6/16/08

(Suzlon rotor Corp. has an active return-to-work program. Most temporary restrictions can be accommodated. Please call 507-562-6700 if you have any questions regarding light duty jobs.)

_____ TOTALLY DISABLED: (Dates) From: _____ To: _____

_____ RESTRICTED WORK: Duration of Limitations: 4 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: no contact with resins or chemicals @ work

Next Appt. Date / Time: _____ Provider's Comments: _____

Employee Signature: _____

Physician or Practitioner Signature: B. Kowalski

Type of Practice: (Field of Specialization) FP

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
504 74 7431	~~6-12-08~~ 5-24-08

EMPLOYEE	Date of Birth
Larry Mohr	3-24-63

EMPLOYER: CMG

INSURER/SELF-INSURER/TPA:

INSURER CLAIM NUMBER:

Date of most recent examination by this office: 6-12-08 (date)

Select the appropriate option(s) below and fill in the applicable dates.

1. ☐ Employee is able to work without restrictions as of 6/16/08 (date)

2. ☐ Employee is able to work with restrictions, from 6/12/08 (date) to 6/16/08 (date)

The restrictions are:

no contact c resins or chemicals @ work

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)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER	B Kocourek	
ADDRES 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	STATE	LICENSE #/REGISTRATION #
CITY UPIN D25406 NPI 1699738559	AREA CODE / TELEPHONE #	DATE SIGNED 6/12/08

MN RW01 (7/01)

Health Care Provider Report

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

HC01

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
504747431	~~6-12-08~~ 5-24-08	3-21-63
EMPLOYEE: Larry Mohr	EMPLOYER: CMG	
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: 6-12-08 (date)

2. Diagnosis (include all ICD-9-CM codes):
allergic contact dermatitis + conjunctivitis

3. History of injury or disease given by employee:
was working c resin in finishing dept et was on gloves et building is full of dust, pt touched eye et face et arms.

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: 6/12/08 (date)

9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) ☒ No ☐ Yes Date reached:

10. Has the employee sustained any permanent partial disability from the injury? ☐ No ☐ Yes ☒ Too early to determine
The permanent partial disability is % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

NAME (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER ADDRESS 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 CITY UPIN D25406 NPI 1699738559	B. Kocourek	
	STATE	LICENSE #/REGISTRATION #
	AREA CODE / TELEPHONE #	DATE SIGNED 6/12/08

MN HC01 (7/01).

MEDTOX LABORATORIES INC.
402 WEST COUNTY ROAD D
ST. PAUL, MN 55112
651-636-7466

Jennifer A. Collins, Ph.D.

9999

Post-Accident

COMPUTER-GENERATED LABORATORY REPORT

93470
SUZLON ROTOR CORPORATION
1711 S HWY 75
PIPESTONE, MN 56164

PATIENT NAME
MOHR,LARRY

PATIENT I.D. NO. V8860002
AGE
SEX
SPECIMEN H6440594

SUZLON
504-74-7431

DATE COLLECTED	TIME COLLECTED	DATE RECEIVED	DATE REPORTED
05/24/2008	07:55	05/28/2008	05/28/2008 1:01PM

TEST(S) REQUESTED	RESULTS	UNITS	THERAPEUTIC RANGE
DRUGS OF ABUSE SCREEN			
AMPHETAMINES	NEGATIVE	ng/ml	
BARBITURATES	NEGATIVE	ng/ml	
BENZODIAZEPINES	NEGATIVE	ng/ml	
COCAINE METABOLITE	NEGATIVE	ng/ml	
OPIATES	NEGATIVE	ng/ml	
PHENCYCLIDINE (PCP)	NEGATIVE	ng/ml	
MARIJUANA (THC) METABOLITE	NEGATIVE	ng/ml	
CREATININE, URINARY	70.6	mg/dl	>20

THE DRUGS IN THIS PROFILE ARE SCREENED BY IMMUNOASSAY. ANY POSITIVE RESULT IS CONFIRMED BY GAS CHROMATOGRAPHY WITH MASS SPECTROMETRY (GC/MS). THE FOLLOWING THRESHOLD CONCENTRATIONS ARE USED FOR THIS ANALYSIS:

DRUG	SCREENING THRESHOLD	CONFIRMATION THRESHOLD
AMPHETAMINES	1000 NG/ML	500 NG/ML
BARBITURATES	300 NG/ML	300 NG/ML
BENZODIAZEPINES	300 NG/ML	300 NG/ML
COCAINE METABOLITE	300 NG/ML	150 NG/ML
OPIATES	2000 NG/ML	2000 NG/ML
PHENCYCLIDINE	25 NG/ML	25 NG/ML
MARIJUANA METABOLITE	50 NG/ML	15 NG/ML

ALTERNATE EXPLANATIONS SHOULD BE CONSIDERED FOR ANY POSITIVE RESULT.

ADULTERATION SCREEN - OXIDANTS			
NITRITES	NEGATIVE	ug/ml	< 200
CHROMIUM	NEGATIVE	ug/ml	< 50

NITRITES AND CHROMATES ARE SCREENED BY COLORIMETRIC METHODS. POSITIVE RESULTS ARE CONFIRMED BY ALTERNATE METHODOLOGY. NITRITE LEVELS GREATER THAN 500 UG/ML AND/OR CHROMIUM LEVELS IN EXCESS OF 50 UG/ML ARE CONSISTENT WITH ADULTERATION.

Certified by: SETTERSTROM,RYAN ** FINAL REPORT **

Collected at 5078255811 MEDTOX collection site #481
PIPESTONE COUNTY MED CENTER
PIPESTONE, MN

Report of Work Ability

See Instructions on Reverse Side

RW01

DO NOT USE THIS SPACE

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Enter dates in MM/DD/YYYY format.

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(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
504747431	~~5-24-08~~ 5-23-08
EMPLOYEE: Larry Mohn	Date of Birth: 3-24-63
EMPLOYER: Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 5-24-08 (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 5-24-08 (date) to 5-26-08 (date)

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

NAME (Type or Print)	SIGNATURE	DEGREE
Dr. Matt Veil	Matt Veil MD	MD
ADDRESS: 420 4th Ave SW	STATE: MN	LICENSE #/REGISTRATION #: MN 45307
CITY: Pipestone STATE: MN ZIP CODE: 56164	AREA CODE: 507 TELEPHONE #: 825-5700	DATE SIGNED: 05-28-08

MN RW01 (7/01)

Health Care Provider Report

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

HC01

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

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
504447431	5-24-08	3-24-63
EMPLOYEE: Larry Mohr	EMPLOYER: Suzlon Rotor	
INSURER/SELF-INSURER/TPA	INSURER CLAIM NUMBER	
INSURER ADDRESS		
CITY	STATE ZIP CODE	

REQUESTER must specify all items to be completed by health care provider. ☐ Items: _____ ☐ MMI (#9) ☐ PPD (#10)

HEALTH CARE PROVIDER TO COMPLETE ITEMS REQUESTED ABOVE

1. Date of first examination for this injury by this office: 5-24-08 (date)

2. Diagnosis (include all ICD-9-CM codes):
Conjunctivitis

3. History of injury or disease given by employee:
? Fiber fragment in eye

4. In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? ☐ No ☐ Yes

5. Is there evidence of pre-existing or other conditions that affect this disability? ☒ No ☐ Yes If yes, describe:

6. Is further treatment of this injury or referral to another doctor planned? ☒ No ☐ Yes If yes, describe:

7. Has surgery been performed? ☒ No ☐ Yes If yes, date and describe: (date)

8. Attach the most recent Report of Work Ability. Date of report: 5-24-08 (date)

9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) ☒ No ☐ Yes Date reached:

10. Has the employee sustained any permanent partial disability from the injury? ☐ No ☐ Yes ☐ Too early to determine
The permanent partial disability is % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

NAME (Type or Print): Dr. Matt Veil	SIGNATURE: Matt Veil MD		DEGREE: MD
ADDRESS: 920 4th Ave SW	STATE: MN	LICENSE #/REGISTRATION #: 45307	
CITY: Pipestone STATE: MN ZIP CODE: 56164	AREA CODE: 507	TELEPHONE #: 825-5700	DATE SIGNED: 05-28-08

MN HC01 (7/01).

ACCIDENT REPORTING PROCEDURES

Employees are required to report all job related injuries to your Manager or Human Resources immediately of the occurrence. *The Manager with the Employee will conduct an accident investigation.* Human Resources or the Manager may provide first aid treatment. If your injury needs to be seen by a medical provider:

1. **A medical referral form must be picked up from the Human Resources or the Manager to take along to the medical provider before each medical visit (except for emergencies).**

2. **The completed medical referral form must be returned immediately to the Human Resources after the medical providers' visit along with the date and time of next appointment.**

3. Any change in attending medical providers must be approved by the Insurance Carrier or coordinated with the Human Resources.

If your job assignment aggravates an already existing physical condition, notify your immediate Manager and Human Resources. A review of your job assignment will be made.

5. **Return to Work Assignments** are used to provide short-term work that accommodates restrictions of Employees as early as possible after an injury. Our goal is to maintain regular contact with the Employee, provide support, maintain a safe work environment during the convenient period, avoid pitfalls of disability and keep the person gainfully employed within their present medical restrictions until returned to their regular job. Medical placement in to a temporary return to work assignment is accomplished by written approval from a physician with the assistance from an Occupational Specialist and CMG Management.

Employees will be retained within their job classifications whenever possible. If the employee remains on restricted duty regular progress meetings will be scheduled. If the Employee cannot return to their regular job within a reasonable time period, (i.e. sixty to ninety calendar days) the Employee may be considered for alternate placement within CMG or Outplacement Rehabilitation.

Regular communication must be maintained with your Manager and Human Resources after any work related injury has occurred. *Future medical providers' visits or absences should be coordinated through Human Resources for accurate reporting of Employees medical condition.* Failure to comply with this policy may result in disciplinary action or cause a delay in Insurance benefits.

Clocking and pay procedure: Employee's if leaving the building will clock out and will not be paid by CMG while attending appointments. All lost time hours of pay will be paid by submitting by the employee to the insurance carrier and reimburse at 66 2/3% of their straight time wages (less applicable taxes) in accordance with State Worker's Compensation laws.

I have read received a copy and will comply with these procedures or be subject to disciplinary action up to and including termination of employment.

Employee Signature Jerry S. Mohr Date: 6-12-08

Submit This Form

Minnesota Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road North
St. Paul, MN 55155-4305
(651) 284-5030

First Report of Injury

See Instructions on Reverse Side.
Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

FR01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #
504-74-7431	

3. DATE OF CLAIMED INJURY	4. Time of injury		5. Time employee began work on date of injury	
5/24/2008	02:00	☐ am ☑ pm	07:00	☑ am ☐ pm

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

9. Home address	10. Home phone #	11. Date of birth
513 S. Prairie Ave Apt#2	(605) 413-7078	3/24/1963

City	State	Zip Code	12. Occupation	13. Regular department	14. Date hired
Sioux Falls	SD	57104	Production Worker	Finishing	3/10/2008

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status		
$400.00	$10.00	8	6	☑ Full time ☐ Seasonal	☐ Part time ☐ Volunteer	

20. Weekly value of:	Meals	Lodging	2nd income	21. Apprentice	
	$0.00	$0.00	$0.00	☐ Yes	☑ No

22. **Tell us how the injury occurred and what the employee was doing before the incident (give details).** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

Got resin in his left eye accidentally by rubbing his eyes.

23. What was the injury or illness (include the part(s) of body)? *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist*	24. What tools, equipment, machines, objects, or substances were involved? *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard*
Eyes	Resin

25. Did injury occur on employer's premises? ☑ Yes ☐ No If no, indicate name and address of place of occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☑ No lost time on DOI
	28. Date employer notified of injury 6/12/2008	29. Date employer notified of lost time
	30. Return to work date 5/24/2008	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit ☑ Yes ☐ No
507-825-5700	Pipestone Medical Group 920 4th Ave SW Pipestone MN 56164	35. Overnight in-patient ☐ Yes ☑ No

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)
CORPORATE MANAGEMENT GROUP INC 188602	

38. **Mailing** address	39. Employer FEIN	40. Unemployment ID #
12000 N. WASHINGTON ST. #290		0036373110

City	State	Zip Code	41. Employer's contact name and phone #	
THORNTON	CO	80241	Amanda Carnahan	(303) 920-1425

42. **Physical** address (if different)	43. Witness (name and phone)

City	State	Zip Code	44. NAICS code	45. Date form completed
				06/12/2008

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY** (CA) name (check one)	Insurer TPA
MINNESOTA ASSIGNED RISK PLAN	Berkley Risk Administrators Company, LLC	

47. Insured legal name	52. CA Address
	222 South Ninth Street

48. Policy # or self-insured certificate #	City	State	Zip Code
	Minneapolis	MN	55402

49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #
	06/12/2008	41-1887666	04 - 188602 -

SUPERVISOR'S REPORT OF ACCIDENT

(PLEASE READ AND FOLLOW INSTRUCTIONS ON BACK)

EVERY ACCIDENT SHOULD BE INVESTIGATED AND THE CAUSES CORRECTED SO THAT MORE ACCIDENTS WILL NOT OCCUR. DO NOT OVERLOOK THE SO-CALLED "UNIMPORTANT" CASES, BECAUSE, EXCEPT FOR "CHANCE" THEY COULD ALSO HAVE BEEN SERIOUS. IT IS ONLY BY THOROUGH INVESTIGATION THAT MANY OF THE REAL CAUSES CAN BE DETERMINED AND CORRECTED.

NAME OF EMPLOYEE Larry Mohr COMPANY CORPORATE MANAGEM DEPT. Finishing

DATE OF ACCIDENT 5/24/2008 TIME 2:00 PM DID EMPLOYEE LOSE TIME FROM WORK? YES ☐ NO ☑

HOURS LOST ON DATE OF ACCIDENT 0 HAS EMPLOYEE RETURNED TO WORK? YES ☑ NO ☐

JOB TITLE Production Worker SERVICE WITH THE COMPANY 4 mo YEARS IN PRESENT JOB 4 mo

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING:		CHECK "YES" OR "NO"	
1.	WAS INJURED PERSON PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS?	YES ☑	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.) Got resin in his left eye accidentally by rubbing his eyes.

WITNESSES' NAMES

UNSAFE ACTS. (WHAT DID THE EMPLOYEE OR ANOTHER PERSON DO INCORRECTLY?)

N/A

UNSAFE CONDITIONS. (WHAT UNGUARDED OR UNSAFE CONDITION OF MACHINERY, EQUIPMENT, BUILDING OR PREMISES WAS INVOLVED?)

N/A

ACTIONS TAKEN. (WHAT DID YOU DO TO CORRECT THE CONDITIONS WHICH CAUSED THIS INJURY?)

N/A

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?)

N/A

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

NAME OF DOCTOR OR HOSPITAL Pipestone Medical Group DATE OF INITIAL VISIT 06/12/2008

ADDRESS 920 4th Ave SW, Pipestone, MN 56164 TELEPHONE NUMBER 507-825-5700

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

REASONS WHY It happened while using the materials of the job.

REPORT SUBMITTED BY Ashley Postma DATE 06/12/2008

Administrative Assistant

BRAC 2520 (10/99)