



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

# Suzlon Injury Report

Team Member: Larry G Mohr  
 Date of Occurrence: 5-5-08  
 Time of Occurrence: 8:30 AM  
 Department: Finishing  
 Team Leader: Scott B.  
 Date Reported: 5-5-08

If taken to Doctor, fill out this section

Date of Treatment: 5-5-08  
 Time of Treatment: 9:19 am  
 Doctor: \_\_\_\_\_  
 Drug Test Performed:  Yes  No  
 Drug test date & time: \_\_\_\_\_

Location of where accident occurred (be specific)

Right & Left forearm's

Description of accident / injury

Raised Red Bumps/scabs developed overtime

Witnesses names

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

Reminder to wear all PPE Vinyl Glove Amshoevis  
and Apron Also to wash off any Resin contact immediately

Employee Feedback

Larry G Mohr  
 Team Member Signature

5-5-08  
 Date

Scott B.  
 Manager Signature

5-5-08  
 Date

Human Resources Signature

Date

**RECEIVED**  
 MAY 05 2008



# 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

*Janey G. Anshin*

Date:

5-5-08

**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.



DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY # 504-74-7431		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 5/5/2008		4. Time of injury 08:30	5. Time employee began work on date of injury 07:00
6. EMPLOYEE Name (last, first, middle) Mohr Larry		7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried
9. Home address 513 S. Prairie Ave Apt#2		10. Home phone # (605) 413-7078	11. Date of birth 3/24/1963
City Sioux Falls	State SD	Zip Code 57104	12. Occupation Production Worker
13. Regular department Finishing		14. Date hired 3/10/2008	
15. Average weekly wage \$400.00	16. Rate per hour \$10.00	17. Hours per day 8	18. Days per week 6
19. Employment Status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> 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."  Breaking out into rash/scabs/bumps from working with resin and fiberglass overtime.			
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 and left forearms		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. resin, fiberglass	
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		26. Date of first day of any lost time	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 5/5/2008	29. Date employer notified of lost time
		30. Return to work date 5/5/2008	31. Date of death
32. TREATING PHYSICIAN (name, address, and phone)  507-825-5700		33. HOSPITAL/CLINIC (name and address) (if any) Pipestone Medical Group 920 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 # 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 05/05/2008	
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 05/05/2008	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 Larry Mohr COMPANY CORPORATE MANAGEM DEPT. Finishing  
DATE OF ACCIDENT 5/5/2008 TIME 8:30 AM DID EMPLOYEE LOSE TIME FROM WORK? YES  NO   
HOURS LOST ON DATE OF ACCIDENT 4 mo 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 <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.) Breaking out into rash/scabs/bumps from working with resin and fiberglass overtime.

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?) \_\_\_\_\_

Remind employees to wear all PPE, vinyl gloves, armsleeves, and aprones. Also to wash off any resin contact right away.

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 Medical Group DATE OF INITIAL VISIT 05/05/2008  
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 happend while at work and working with the materials of the job.

REPORT SUBMITTED BY Ashley Postma DATE 05/05/2008