



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

Suzlon Injury Report

181
4-29-2008
CMG
5-15-08

Team Member: LeeAnn Trujillo
 Date of Occurrence: 25 April 08
 Time of Occurrence: after 1:00 Am
 Department: Quality C.
 Team Leader: Tejendra
 Date Reported: 28 April 08

If taken to Doctor, fill out this section
 Date of Treatment: 5-15-08
 Time of Treatment: 1:40
 Doctor: _____
 Drug Test Performed: Yes No
 Drug test date & time: _____

Location of where accident occurred (be specific)

Outside at the parking lot

Description of accident / injury

I was walking to my car and I slip and fell & hit my head and hurt my Back & elbow

Witnesses names

Michelle Mercado (Bag: 363)

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

Employee Feedback

LeeAnn Trujillo
 Team Member Signature

28 April 08
 Date

Tejendra Patel Patel
 Manager Signature

 Date

Thomas Turk
 Human Resources Signature

4-29-2008
 Date

April 25 was the evening of snow storm, several inches of snow preceded with rain and high wind. Parking lot was not completely cleared since the storm

RECEIVED
MAY 16 2008

BY:.....



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

Referral for Medical Treatment Report to Employer

Employee Name: Lee Ann Trujillo Date of Injury: 4-25-2008

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 Houcek Date / Time of Appt: 5-15-2008 1:40

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:

Wausau Insurance
PO Box 8016
Wausau, WI 54402
1-877-870-1542

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

Diagnosis: contusion @ post ribs _____ Non-work related

to fall _____ Undetermined

Treatment Plan: NSAID, muscle relaxant Work related

RETURN TO WORK: With No Limitations ^{ice} Date: 5/16/08

(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: _____ 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: B. Prunicki Date: _____

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 # 455-49-6173		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 4/25/2008		4. Time of injury 01:00	<input checked="" type="checkbox"/> am <input type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Trujillo LeeAnn		7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Unmarried
9. Home address 110 2ND AVE SE Apt 104		10. Home phone # (507) 562-0341	11. Date of birth 9/25/1976
City Pipestone	State MN	Zip Code 56164	12. Occupation Production Worker
13. Regular department Process Control		14. Date hired 2/12/2007	
15. Average weekly wage \$424.00	16. Rate per hour \$10.60	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 nd 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." LeeAnn was walking to my car and I slip and fell and hit my head and hurt my back and elbow.			
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. head, back, elbow		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. car	
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 5/16/2008	29. Date employer notified of lost time
		30. Return to work date 4/25/2008	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) Michelle Mercado	
City	State	Zip Code	44. NAICS code
		45. Date form completed 05/16/2008	
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 05/16/2008	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 LeeAnn Trujillo COMPANY CORPORATE MANAGEM DEPT. Process Control
 DATE OF ACCIDENT 4/25/2008 TIME 1:00 AM DID EMPLOYEE LOSE TIME FROM WORK? YES NO
 HOURS LOST ON DATE OF ACCIDENT 0 HAS EMPLOYEE RETURNED TO WORK? YES NO
 JOB TITLE Production Worker SERVICE WITH THE COMPANY 1 year YEARS IN PRESENT JOB 1 year

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.) LeeAnn was walking to my car and I slip and fell and hit my head and hurt my back and elbow.

WITNESSES' NAMES Michelle Mercado

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 05/15/2008

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 in the parking lot and not while working on the floor.

REPORT SUBMITTED BY Ashley Postma

DATE 05/16/2008

Administrative Assistant