

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 # 504-80-0706		2. OSHA Case #					
3. DATE OF CLAIMED INJURY 7/12/2008		4. Time of injury 03:20		5. Time employee began work on date of injury			
6. EMPLOYEE Name (last, first, middle) Rivas Marcia				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 1508 E. Rice Street			10. Home phone # (605) 360-4424		11. Date of birth 10/5/1975		
City Sioux Falls		State SD		Zip Code 57103		12. Occupation Production	
				13. Regular department Finishing		14. Date hired 5/21/2008	
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"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer			
20. Weekly value of: Meals		Lodging		2nd 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." Grinding outside on blades broke out in rash							
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. Broke out in rash from grinding				24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.			
25. Did injury occur on employer's premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate name and address of place of occurrence Suzlon Rotor Pipestone MN 56164		26. Date of first day of any lost time No 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 7/14/2008		29. Date employer notified of lost time			
		30. Return to work date		31. Date of death			
32. TREATING PHYSICIAN (name, address, and phone) Avera Pipestone			33. HOSPITAL/CLINIC (name and address) (if any) Pipestone County Med Center Pipestone MN 56164			34. Emergency Room Visit <input type="checkbox"/> Yes <input type="checkbox"/> No	
						35. Overnight in-patient <input type="checkbox"/> Yes <input 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 # Sarah Evans (507) 562-6712	
42. Physical address (if different)				43. Witness (name and phone)			
City		State		Zip Code		44. NAICS code	
						45. Date form completed 07/15/2008	
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 07/15/2008		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 Marcia Rivas COMPANY CORPORATE MANAGEM DEPT. Finishing
 DATE OF ACCIDENT 7/12/2008 TIME 3:20 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 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.) Grinding outside on blades broke out in rash

WITNESSES' NAMES _____

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

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?)
Be cautious when grinding

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 Avera DATE OF INITIAL VISIT 07/14/2008
 ADDRESS Pipestone, TELEPHONE NUMBER _____

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES NO
 REASONS WHY Broke out in rash no preventive

REPORT SUBMITTED BY Joe Greco DATE 07/15/2008
(507) 562-6811

7-14-2008
282
OSTHA Log 688

 SUZLON S.R.C. - Pipestone, MN U.S.A.		<h1>Suzlon Accident Report</h1>
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Team Member: Marcia Rivas Taken to Hospital or Clinic? Y N

Date of Occurrence: 7-12-08 Is This a Near Miss? Y N

Time of Occurrence: 3:20

Date Reported: 7-14-08 Team Leader: Jaal Swenson

Department: finishing Day shift Night shift

Location of where accident occurred (be specific)

grinding outside on Blades come in on Monday
Started working and really flared up with cash
 Description of accident / injury
arms ground neck and chest rashing up
real good

Witnesses names

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

already had a suit and ^{face} shield on

Employee Feedback

Marcia Rivas
 Team Member Signature

7-14-08
 Date

*Issued steroid
 prescription to address*

Jaal Swenson
 Team Leader Signature

7-14-08
 Date

Thomas Fute
 Safety Officer Signature

7-14-2008
 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



Medical Referral to Employer

Employee Name: Marcia Rivas 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.

Marcia Rivas Employee Signature 7-14-08 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:
**Berkley Risk
PO BOX 59143
Minneapolis, MN 55459-0413
(612)766-3000**
Incomplete billings or those mailed directly to Corporate Management Group may result in slow payment processes.

Diagnosis: allergic contact dermatitis _____ Non-work related
_____ Undetermined

Treatment Plan: Mohel dosepack, Zyrtec _____ Work related

RETURN TO WORK: With No Limitations Date: 7/14/08
(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. Rasmussen Date: 7/14/08

Please fax back to 507.562.6800 - Attn CMG.

3 PART DRUGS OF ABUSE TEST REQUEST



SPECIMEN ID **V9272015**



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

Account # _____

Social Security No, Employee No. or other Identification No. _____

Donor I.D. **504800706**

Donor Name (last, first) or SSN **Rivas Marcia K**

Donor Daytime Phone **6052014083** Referring Phys / Company **Suzlon Rotor**

Specimen Type:
 Blood Urine
 Oral Fluid

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 *Marcia Rivas* DATE **07/14/2008**

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) YES No, Remark Required _____

81605

4 To be Completed by COLLECTOR

Collection Site Location: Facility and Address **401 PIPESTONE COUNTY MED CENTER PIPESTONE, MN 56164**

Collection Site Phone No. **(507) 825 6166** Fax No. **(507) 825 6081**

Date and Time of Collection Month **07** Day **14** Year **2008** Hour **10** Minutes **00** am pm

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.

Caroline Bot
 Signature of Collector
Caroline Bot
 (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





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 Marcio Rivas Date: 7-14-08