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

Suzlon Injury Report

Team Member: Marcie DeZeeuw **Taken to Hospital or Clinic? Y___ N** X

Date of Occurrence: 11-13-07 **Day shift** X **Night shift** ___

Time of Occurrence: AM **Department:** Moulds

Team Leader: Scott Bloemendaal

Date Reported: 11-14-07

Location of where accident occurred (*be specific*)

X-side of Red Line

Description of accident / injury

Sore elbow (left) from pulling / shelling X side blade.

Witnesses names

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

Change the way you Remove Aldug materials / Diff positions

Employee Feedback

Marcie A DeZeeuw — **Team Member Signature** — 11-14-07 — **Date**

S Bloemendaal — **Team Leader Signature** — 11-14-07 — **Date**

Jan Boer — **Human Resources Signature** — 11-28-07 — **Date**

RECEIVED
FEB 08 2008
BY:.....

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 # 504-86-7499	2. OSHA Case #		
3. DATE OF CLAIMED INJURY 11/13/2007	4. Time of injury ☑ am ☐ pm	5. Time employee began work on date of injury 07:00 ☑ am ☐ pm	
6. EMPLOYEE Name (last, first, middle) DeZeeuw Marcie		7. Gender ☐ M ☑ F	8. Marital Status ☐ Married ☐ Unmarried
9. Home address 256 Rock Street		10. Home phone # (507) 347-3188	11. Date of birth 12/4/1959
City Holland	State MN	Zip Code 56139	12. Occupation Production Worker
13. Regular department Mould		14. Date hired 10/23/2007	
15. Average weekly wage $400.00	16. Rate per hour $10.00	17. Hours per day 40	18. Days per week 8
19. Employment Status ☑ Full time ☐ Part time ☐ Seasonal ☐ Volunteer			
20. Weekly value of: Meals $0.00	Lodging $0.00	2nd income $0.00	21. Apprentice ☐ 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."*

Sore elbow (left) from pulling/sheilling side of 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* left elbow	24. What tools, equipment, machines, objects, or substances were involved? *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard* shelling (green mesh)

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 2/7/2008	29. Date employer notified of lost time
	30. Return to work date 11/13/2007	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 ☑ Yes ☐ No 35. Overnight in-patient ☐ Yes ☑ 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 # Ashley Postma (507) 562-6807
42. **Physical** address (if different)			43. Witness (name and phone)
City	State	Zip Code	44. NAICS code
			45. Date form completed 02/11/2008

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 02/11/2008	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 Marcie DeZeeuw COMPANY CORPORATE MANAGEM DEPT. Mould

DATE OF ACCIDENT 11/13/2007 TIME AM DID EMPLOYEE LOSE TIME FROM WORK? YES ☑ NO ☐

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

JOB TITLE Production Worker SERVICE WITH THE COMPANY 5 mo YEARS IN PRESENT JOB 5mo

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.) Sore elbow (left) from pulling/sheilling side of blade.

WITNESSES' NAMES

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?)

Educated employee to change the wat you remove aiding materials. Use different positions.

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

Educate employees the correct way to remove materials.

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 02/07/2008

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 Because it happened way back in November and she is just reporting it to us now.

REPORT SUBMITTED BY Ashley Postma DATE 02/11/2008

Administrative Assistant

BRAC 2520 (10/99)

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

Referral for Medical Treatment Report to Employer

Employee Name: Marcie Dezeeuw **Date of Injury:** 11-13-07

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.

Marcie A Dezeeuw
Employee Signature

02.07.08
Date

Medical Provider Kocourek **Date / Time of Appt:** 2/7/08 1530

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: lateral epicondylitis ② elbow ____ Non-work related

____ Undetermined

Treatment Plan: NSAID, ice, forearm support ban X Work related

RETURN TO WORK: X **With No Limitations** **Date:** 2/8/08

(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: 2 wks **Provider's Comments:** reg duties

Medical Provider Signature: B. Kocourek **Date:** 2/7/08

Dawn

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
504 86 7499		12-4-59
EMPLOYEE: Maraie Dezeeuw	EMPLOYER: Suzlon	
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: 2-7-08 (date)

2. Diagnosis (include all ICD-9-CM codes):
lateral epicondylitis (L) elbow

3. History of injury or disease given by employee:
hurt elbow pulling green mesh (shelling)

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: 2/7/08 (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) BRUCE W KOCOUREK, DO	SIGNATURE B. Kocourek		DEGREE
ADDRESS PIPESTONE COUNTYMEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825 5700 FAX 507-825-4744	STATE	LICENSE #/REGISTRATION #	
CITY DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #	DATE SIGNED 2/7/08

MN HC01 (7/01).

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 86 7499	
EMPLOYEE: Marcie Dezeeuw	Date of Birth: 12-4-59
EMPLOYER: Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 2-7-08 (date)

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

1. [X] Employee is able to work without restrictions as of 2/8/08 (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 _____ (date) to _____ (date)

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

NAME (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONE COUNTYMEDICAL 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: 2/7/08

MN RW01 (7/01)