



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

# Suzlon Accident Report

Team Member: Maria Morales

Taken to Hospital or Clinic? Y  N

Date of Occurrence: 1-5-07

Is This a Near Miss? Y  N

Time of Occurrence: 2:00 p.m.

Date Reported: 1-7-07

Team Leader: Ken Klosterman

Department: \_\_\_\_\_

Day shift  Night shift

Location of where accident occurred (be specific)

Description of accident / injury

Loading racks pulled a muscle in her  
Shoulder

Witnesses names

Kim Whipple

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

use a forklift to load glass

Employee Feedback

X Maria Morales

Team Member Signature

Ken Klosterman

Team Leader Signature

1-7-08

Date

1-7-08

Date

Safety Officer Signature

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*



# 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: MARIA MORALES DE CAJESO Date: 1/7/08

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: \_\_\_ With No Limitations Date: \_\_\_\_\_

**(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: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Physician or Practitioner Signature: Rob Adams

Type of Practice: (Field of Specialization) Int med



# Medical Referral to Employer

Employee Name: MARIA MORALES DE CORNEJO 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.

Maria Morales  
Employee Signature

1/7/08  
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: Shoulder Muscle Sprain \_\_\_\_\_ Non-work related

\_\_\_\_\_ Undetermined

Treatment Plan: NOPT \_\_\_\_\_  Work related

**RETURN TO WORK:** \_\_\_\_\_ With No Limitations Date: \_\_\_\_\_  
(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: 10 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: Rod Adames Date: 1/7/08

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 # 631-09-2086		2. OSHA Case #		DO NOT USE THIS SPACE			
3. DATE OF CLAIMED INJURY 1/5/2008		4. Time of injury 02:00 <input type="checkbox"/> am <input checked="" type="checkbox"/> pm		5. Time employee began work on date of injury 07:00 <input type="checkbox"/> am <input checked="" type="checkbox"/> pm			
6. EMPLOYEE Name (last, first, middle) Morales Maria DeCorrea			7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Unmarried		
9. Home address 811 Omaha Ave			10. Home phone # (507) 350-9739		11. Date of birth 6/11/1958		
City Worthington		State MN		Zip Code 56187		12. Occupation laborer	
				13. Regular department prefab		14. Date hired 9/28/2007	
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"/> Seasonal <input type="checkbox"/> Part time <input type="checkbox"/> Volunteer			
20. Weekly value of: Meals		Lodging		2 <sup>nd</sup> 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." loading racked, pulled a muscle in shoulder							
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. pulled muscle in her shoulder				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 1/7/2007		27. Employer paid for lost time on day of injury (DOI) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI			
		28. Date employer notified of injury 1/7/2007		29. Date employer notified of lost time 1/7/2007			
		30. Return to work date 1/7/2007		31. Date of death			
32. TREATING PHYSICIAN (name, address, and phone) christensen 920 th Ave SW Pipestone MN 56164 (507) 825-5700			33. HOSPITAL/CLINIC (name and address) (if any) Pipestone County Med Cln. 920 th 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 # CMG (507) 562-6808	
42. Physical address (if different)				43. Witness (name and phone) Kim Whipple (507) 562-6750			
City		State		Zip Code		44. NAICS code	
						45. Date form completed 01/08/2008	
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 01/08/2008		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 Maria DeCorrejo Morales COMPANY CORPORATE MANAGEM DEPT. prefab  
DATE OF ACCIDENT 1/5/2008 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 laborer 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 type="checkbox"/>	NO <input checked="" 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 type="checkbox"/>	NO <input checked="" type="checkbox"/>

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.) loading racked, pulled a muscle in shoulder

WITNESSES' NAMES Kim Whipple

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?)

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 christensen DATE OF INITIAL VISIT 01/07/2007  
ADDRESS 920 th 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 I'm not sure

REPORT SUBMITTED BY Ken Klosterman  
(507) 562-6750

DATE 01/08/2008