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 Klostermar

**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 — 1-7-08

**Team Member Signature** — **Date**

Ken K — 1-7-08

**Team Leader Signature** — **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*

# 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.

X 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: Naprosyn X **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: _____

X **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): ____
X Restricted use of hand: X Right ___Left X 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:** RA Adnesian **Date:** 1/7/08

*Please fax back to 507.562.6800 – Attn CMG.*

# 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 CONESTO Date: 1/7/08

Is employee able to perform the functions of his/her position? ___ Yes X No

Any restrictions? X 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): _____

X Restricted use of hand: X Right ___Left X 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: _____

Type of Practice: (Field of Specialization) Int med

*Please fax back to 507.562.6800 – Attn CMG.*

Return to Your Home Page

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.

FRO1

DO NOT USE THIS SPACE

| 1. EMPLOYEE SOCIAL SECURITY # | 2. OSHA Case # |
|---|---|
| 631-09-2086 | |

| 3. DATE OF CLAIMED INJURY | 4. Time of injury | | 5. Time employee began work on date of injury | |
|---|---|---|---|---|
| 1/5/2008 | 02:00 | ☐ am ☑ pm | 07:00 | ☑ am ☐ pm |

| 6. EMPLOYEE Name (last, first, middle) | | 7. Gender | 8. Marital Status |
|---|---|---|---|
| Morales | Maria DeCorre | ☐ M ☑ F | ☐ Married ☑ Unmarried |

| 9. Home address | 10. Home phone # | 11. Date of birth |
|---|---|---|
| 811 Omaha Ave | (507) 350-9739 | 6/11/1958 |

| City | State | Zip Code | 12. Occupation | 13. Regular department | 14. Date hired |
|---|---|---|---|---|---|
| Worthington | MN | 56187 | laborer | prefab | 9/28/2007 |

| 15. Average weekly wage | 16. Rate per hour | 17. Hours per day | 18. Days per week | 19. Employment Status | | |
|---|---|---|---|---|---|---|
| $400.00 | $10.00 | 8 | 5 | ☑ Full time ☐ Seasonal | ☐ Part time ☐ Volunteer | |

| 20. Weekly value of: | Meals | Lodging | 2nd income | 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."*

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* | 24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard* |
|---|---|
| pulled muscle in her shoulder | |

| 25. Did injury occur on employer's premises? | 26. Date of first day of any lost time | 27. Employer paid for lost time on day of injury (DOI) |
|---|---|---|
| ☑ Yes ☐ No<br>If no, indicate name and address of place of occurrence<br>Suzlon rotor<br>Pipestone MN 56164 | 1/7/2007 | ☑ Yes ☐ No ☐ 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) | 33. HOSPITAL/CLINIC (name and address) (if any) | 34. Emergency Room Visit | 35. Overnight in-patient |
|---|---|---|---|
| christensen<br>920 th Ave SW<br>Pipestone MN 56164<br>(507) 825-5700 | Pipestone County Med Ctn.<br>920 th Ave SW<br>Pipestone MN 56164 | ☑ Yes ☐ No | ☐ Yes ☑ No |

| 36. **EMPLOYER** Legal name | 37. EMPLOYER DBA name (if different) |
|---|---|
| CORPORATE MANAGEMENT GROUP INC 188602 | |

| 38. **Mailing** address | 39. Employer FEIN | 40. Unemployment ID # |
|---|---|---|
| 12000 N. WASHINGTON ST. #290 | | 0036373110 |

| City | State | Zip Code | 41. Employer's contact name and phone # | |
|---|---|---|---|---|
| THORNTON | CO | 80241 | 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 | 51. **CLAIMS ADMIN COMPANY** (CA) name (check one) | Insurer / TPA |
|---|---|---|
| MINNESOTA ASSIGNED RISK PLAN | Berkley Risk Administrators Company, LLC | |

| 47. Insured legal name | 52. CA Address |
|---|---|
| | 222 South Ninth Street |

| 48. Policy # or self-insured certificate # | City | State | Zip Code |
|---|---|---|---|
| | Minneapolis | MN | 55402 |

| 49. Insurer FEIN | 50. Date insurer received notice | 53. CA FEIN | 54. Claim # |
|---|---|---|---|
| | 01/08/2008 | 41-1887666 | 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 ☑ | 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.) 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 01/07/2008

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 DATE 01/08/2008

(507) 562-6750

BRAC 2520 (10/99)