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

Suzlon Accident Report

Team Member: Megan Fehl

Taken to Hospital or Clinic? Y___ N___

Date of Occurrence: 2-28-08

Is This a Near Miss? Y___ N___

Time of Occurrence: _____

Date Reported: 3-3-08

Team Leader: Lisa Gorter

Department: Mould

Day shift X Night shift ___

Location of where accident occurred (*be specific*)

Mould

Description of accident / injury

When laying pasta, Megan got pasta on her arm and now has a rash

Witnesses names

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

She was wearing the proper PPE, but still got pasta on her, make sure you clean pasta off your right away.

Employee Feedback

Megan Fehl — 3-3-08

Team Member Signature — **Date**

Lisa Gorter — 3-3-08

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: Megan Fehl **Date of Injury:** 2-28-08

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 _____ **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: contact dermatitis ____ **Non-work related**

_____ ____ **Undetermined**

Treatment Plan: Medrol dosepak, Zyrtec ___x___ **Work related**

RETURN TO WORK: ___x___ **With No Limitations** **Date:** 3/3/08

(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:** _____

maximal skin protection

Medical Provider Signature: B Rasmussen **Date:** 3/3/08

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: Megan Fehl Date: 3-3-08

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

Any restrictions? X Yes ___ No If yes, please describe restriction(s) and duration below:

RETURN TO WORK: X With No Limitations Date: 3/3/08

(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

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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: maximal skin protection

Next Appt. Date / Time: _____ Provider's Comments: _____

Employee Signature: Megan Fehl

Physician or Practitioner Signature: B Ramamurthy

Type of Practice: (Field of Specialization) FP

Please fax back to 507.562.6800 – Attn CMG.

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 _____ Date: 3-3-08

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 2-28-08
EMPLOYEE	Date of Birth 7-3-86
EMPLOYER	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office 3-3-08 (date)

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

1. [X] Employee is able to work without restrictions as of 3/3/08 (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	B Kocourek	DO
ADDRES PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164	STATE	LICENSE #/REGISTRATION #
507-825-5700 FAX 507-825-4744	AREA CODE	TELEPHONE # / DATE SIGNED 3-3-08
CITY DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559		

MN RW01 (7/01)

Health Care Provider Report

See Instructions on Reverse Side
(WHEN COMPLETED RETURN TO REQUESTER)

HC01

DO NOT USE THIS SPACE

Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
	2-28-08	7-3-86
EMPLOYEE	EMPLOYER	
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: 3-3-08 (date)

2. Diagnosis (include all ICD-9-CM codes):
contact dermatitis

3. History of injury or disease given by employee:
rash on arms p pasta exposure

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: 3/3/08 (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)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	B. Kocourek	DO
ADDI	STATE	LICENSE #/REGISTRATION #
CITY DE	AREA CODE	TELEPHONE # / DATE SIGNED 3-3-08

MN HC01 (7/01).