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

Suzlon Accident Report

Team Member: Michael Steffan Taken to Hospital or Clinic? Y ~~N~~ 2:00 7-11-2008

Date of Occurrence: 7-11-08 Is This a Near Miss? Y ~~N~~

Time of Occurrence: 9:35am

Date Reported: 7-11-08 Team Leader: Tanya

Department: Prefab Day shift ~~Night shift~~

Location of where accident occurred (*be specific*)

Prefab TSO White Line

Description of accident / injury

Was moving a TSO by hand w/ 3 other guys & it fell on him.

Witnesses names

Karen, Jaime, Jim

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

Cranes need to work at all times. Preventative maintenance. Also, could have had more people.

Employee Feedback

[signature]	07-11-08
Team Member Signature	**Date**
[signature]	7-11-08
Team Leader Signature	**Date**
[signature]	7-11-2008
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*

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: 7-11

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 #	2. OSHA Case #
473-21-9712	

3. DATE OF CLAIMED INJURY	4. Time of injury	5. Time employee began work on date of injury
7/11/2008	☐ am ☐ pm	☑ am ☐ pm

6. EMPLOYEE Name (last, first, middle)		7. Gender	8. Marital Status
Steffan	Michael	☑ M ☐ F	☐ Married ☑ Unmarried

9. Home address	10. Home phone #	11. Date of birth
624 111th Street	(507) 676-0948	3/21/1988

City	State	Zip Code	12. Occupation	13. Regular department	14. Date hired
Pipestone	MN	56164	Production line	Prefab	4/10/2008

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 ☐ Part time ☐ Seasonal ☐ 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."*

TSO fell on him

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*
TSO fell on him. Was moving it by hand	

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)
Suzlon Pipestone MN 56164	7/10/2008	☐ Yes ☑ No ☐ No lost time on DOI
	28. Date employer notified of injury: 7/10/2008	29. Date employer notified of lost time: 7/10/2008
	30. Return to work date	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit ☐ Yes ☐ No 35. Overnight in-patient ☐ 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) 562-6712

42. **Physical** address (if different)	43. Witness (name and phone)
	Karen, Jaime, and Jim (507) 562-6750

City	State	Zip Code	44. NAICS code	45. Date form completed
				07/11/2008

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: Minneapolis State: MN Zip Code: 55402

49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. Claim #
	07/11/2008	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 Michael Steffan COMPANY CORPORATE MANAGEM DEPT. Prefab

DATE OF ACCIDENT 7/11/2008 TIME _____ DID EMPLOYEE LOSE TIME FROM WORK? YES ☑ NO ☐

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

JOB TITLE Production line SERVICE WITH THE COMPANY _____ YEARS IN PRESENT JOB _____

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.) TSO fell on him

WITNESSES' NAMES Karen, Jaime, and Jim

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 _____ DATE OF INITIAL VISIT _____

ADDRESS _____ TELEPHONE NUMBER _____

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? YES ☐ NO ☐

REASONS WHY _____

REPORT SUBMITTED BY Corrina Leach DATE 07/11/2008

(507) 562-6750

BRAC 2520 (10/99)