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

Suzlon Accident Report

Team Member: Raphael Morales

Taken to Hospital or Clinic? Y___ N X

Date of Occurrence: ~~10:53pm~~ 4-23-08

Is This a Near Miss? Y X N___

Time of Occurrence: 10:53pm

Date Reported: 4-23-08

Team Leader: Luke Anderson

Department: white line mould

Day shift ___ Night shift X

Location of where accident occurred (*be specific*)

white line mould (O side)

Description of accident / injury

was grinding two layers with the Gaurd on and it spun around on him and cut him on the Right middle Finger

Witnesses names

none (I was

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

Employee Feedback

Raphael morales

Team Member Signature — Date

Team Leader Signature — Date: 4-23-08

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*

RECEIVED
APR 23 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 #	2. OSHA Case #
583-79-8291	

3. DATE OF CLAIMED INJURY	4. Time of injury		5. Time employee began work on date of injury	
4/23/2008	10:53	☐ am ☑ pm	03:45	☐ am ☑ pm

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

9. Home address	10. Home phone #	11. Date of birth
1202 S. Bahnson Ave	(605) 728-5995	8/26/1980

City	State	Zip Code	12. Occupation	13. Regular department	14. Date hired
Sioux Falls	SD	57103	Production Worker	Mould	4/7/2008

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status
$424.00	$10.60	8	6	☑ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

20. Weekly value of:	Meals	Lodging	2nd income	21. Apprentice
	$0.00	$0.00	$0.00	☐ 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."*

Was grinding two layers with the guard on and it spun around on him and cut him on the right middle finger.

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.*
right middle finger	grinder.

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: 4/23/2008	29. Date employer notified of lost time
	30. Return to work date: 4/23/2008	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	Amanda Carnahan (303) 920-1425

42. **Physical** address (if different)	43. Witness (name and phone)

City	State	Zip Code	44. NAICS code	45. Date form completed
				04/24/2008

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 #
	04/24/2008	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 Rafael Morales Figueroa COMPANY CORPORATE MANAGEM DEPT. Mould

DATE OF ACCIDENT 4/23/2008 TIME 10:53 PM 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 2 mo YEARS IN PRESENT JOB 2mo

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.) Was grinding two layers with the guard on and it spun around on him and cut him on the right middle finger.

WITNESSES' NAMES _____

UNSAFE ACTS. (WHAT DID THE EMPLOYEE OR ANOTHER PERSON DO INCORRECTLY?) N/A

UNSAFE CONDITIONS. (WHAT UNGUARDED OR UNSAFE CONDITION OF MACHINERY, EQUIPMENT, BUILDING OR PREMISES WAS INVOLVED?) N/A

ACTIONS TAKEN. (WHAT DID YOU DO TO CORRECT THE CONDITIONS WHICH CAUSED THIS INJURY?) N/A

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?) Educate employees how to use the grinder safety.

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 Happened while at work and using tools of the job.

REPORT SUBMITTED BY Ashley Postma DATE 04/24/2008

Administrative Assistant