



Suzlon Accident Report

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

Team Member: Ramon Campos Rea

Taken to Hospital or Clinic? Y N

Date of Occurrence: 5-30-08

Is This a Near Miss? Y N Direct Hit

Time of Occurrence: AM

Date Reported: 6-13-08

Team Leader: Team Leader

Department: Prefab

Day shift Night shift

Location of where accident occurred (be specific)

Prefab Girder

Description of accident / injury

Was pulling glass and had sharp pain in left shoulder.

Witnesses names

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

Employee Feedback

[Signature]
Team Member Signature

06/13/08
Date

[Signature]
Team Leader Signature

6-13-08
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

RECEIVED
JUN 13 2008



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: 08/13/08

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.



DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY # 607-32-6144		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 5/30/2008		4. Time of injury 08:00 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	5. Time employee began work on date of injury 07:00 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Campos Rea Ramon		7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Unmarried
9. Home address 111 1/2 Cedar North		10. Home phone # (507) 449-0399	11. Date of birth 5/17/1967
City Luverne	State MN	Zip Code 56156	12. Occupation Production Worker
13. Regular department Prefab		14. Date hired 4/14/2008	
15. Average weekly wage \$400.00	16. Rate per hour \$10.00	17. Hours per day 8	18. Days per week 6
19. Employment Status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer		20. Weekly value of: Meals: \$0.00 Lodging: \$0.00 2 nd income: \$0.00	
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." Was pulling glass and had a sharp pain in left 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. Left arm and shoulder		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard. glass	
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		26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> No lost time on DOI
28. Date employer notified of injury 6/13/2008		29. Date employer notified of lost time	
30. Return to work date 5/30/2008		31. Date of death	
32. TREATING PHYSICIAN (name, address, and phone) 507-825-5700		33. HOSPITAL/CLINIC (name and address) (if any) Pipestone Medical Group 920 4th 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 # 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 06/13/2008		46. INSURER name MINNESOTA ASSIGNED RISK PLAN	
47. Insured legal name		51. CLAIMS ADMIN COMPANY (CA) name (check one) Insurer Berkley Risk Administrators Company, LLC TPA	
48. Policy # or self-insured certificate #		52. CA Address 222 South Ninth Street	
49. Insurer FEIN		City Minneapolis	State MN
50. Date insurer received notice 06/13/2008		Zip Code 55402	53. CA FEIN 41-1887666
54. Claim # 04 - 188602 -		55. Date form completed	

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 Ramon Campos Rea COMPANY CORPORATE MANAGEM DEPT. Prefab
DATE OF ACCIDENT 5/30/2008 TIME 8:00 AM DID EMPLOYEE LOSE TIME FROM WORK? YES NO
HOURS LOST ON DATE OF ACCIDENT 0 HAS EMPLOYEE RETURNED TO WORK? YES NO
JOB TITLE Production Worker SERVICE WITH THE COMPANY 3 mo YEARS IN PRESENT JOB 3 mo

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 checked="" type="checkbox"/> | NO <input 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 checked="" type="checkbox"/> | NO <input type="checkbox"/> |

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.) Was pulling glass and had a sharp pain in left shoulder.

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?) _____

Received medical attention

REMEDIES. (WHAT SHOULD YOUR ORGANIZATION DO TO PREVENT OTHER INJURIES LIKE THIS?) _____

N/A

MEDICAL CARE. DID EMPLOYEE GO TO DOCTOR OR HOSPITAL? YES NO IF YES, COMPLETE THE FOLLOWING

NAME OF DOCTOR OR HOSPITAL Pipestone Medical Group DATE OF INITIAL VISIT 06/13/2008
ADDRESS 920 4th 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 It happened while using the tools and materials of the job.

REPORT SUBMITTED BY Ashley Postma DATE 06/13/2008
Administrative Assistant