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

Suzlon Injury Report

Team Member: Raul Ortiz

Date of Occurrence: ~~6-6-08~~ 6-7-08

Time of Occurrence: 8:30 AM

Department: Finishing

Team Leader: Antonio Mora

Date Reported: 6-9-08

If taken to Doctor, fill out this section

Date of Treatment: 6-9-08

Time of Treatment:

Doctor:

Drug Test Performed: (Yes) No

Drug test date & time:

Location of where accident occurred (*be specific*)

Finishig Back Row

Description of accident / injury

He was sanding a green blade, some fiber glass got on his Arms

Witnesses names

Jorge Lopez

Corrective action (*include: task, equipment, environmental, and management factors*) – If needs further investigation use form F:ST:02

long sleves shirt may help keep fiber glass off

Employee Feedback

Raul Alfonso Ortiz — 6-12-08

Team Member Signature — **Date**

Manager Signature — **Date**

Human Resources Signature — **Date**

RECEIVED
JUN 13 2008

BY:

MEDTOX LABORATORIES INC.
402 WEST COUNTY ROAD D
ST. PAUL, MN 55112
651-636-7466

Jennifer A. Collins, Ph.D.

9999

Post-Accident

COMPUTER-GENERATED LABORATORY REPORT

93470
SUZLON ROTOR CORPORATION
1711 S HWY 75
PIPESTONE, MN 56164

PATIENT NAME
ORITZ,RAUL

PATIENT I.D. NO. AGE SEX SPECIMEN
V9131624 H6571061

SUZLON ROTOR
638-05-5671

DATE COLLECTED	TIME COLLECTED	DATE RECEIVED	DATE REPORTED
06/09/2008	14:00	06/10/2008	4:41AM 06/11/2008

TEST(S) REQUESTED	RESULTS	UNITS	THERAPEUTIC RANGE
DRUGS OF ABUSE SCREEN			
AMPHETAMINES	NEGATIVE	ng/ml	
BARBITURATES	NEGATIVE	ng/ml	
BENZODIAZEPINES	NEGATIVE	ng/ml	
COCAINE METABOLITE	NEGATIVE	ng/ml	
OPIATES	NEGATIVE	ng/ml	
PHENCYCLIDINE (PCP)	NEGATIVE	ng/ml	
MARIJUANA (THC) METABOLITE	NEGATIVE	ng/ml	
CREATININE, URINARY	56.0	mg/dl	>20

THE DRUGS IN THIS PROFILE ARE SCREENED BY IMMUNOASSAY. ANY POSITIVE RESULT IS CONFIRMED BY GAS CHROMATOGRAPHY WITH MASS SPECTROMETRY (GC/MS). THE FOLLOWING THRESHOLD CONCENTRATIONS ARE USED FOR THIS ANALYSIS:

DRUG	SCREENING THRESHOLD	CONFIRMATION THRESHOLD
AMPHETAMINES	1000 NG/ML	500 NG/ML
BARBITURATES	300 NG/ML	300 NG/ML
BENZODIAZEPINES	300 NG/ML	300 NG/ML
COCAINE METABOLITE	300 NG/ML	150 NG/ML
OPIATES	2000 NG/ML	2000 NG/ML
PHENCYCLIDINE	25 NG/ML	25 NG/ML
MARIJUANA METABOLITE	50 NG/ML	15 NG/ML

ALTERNATE EXPLANATIONS SHOULD BE CONSIDERED FOR ANY POSITIVE RESULT.

ADULTERATION SCREEN - OXIDANTS			
NITRITES	NEGATIVE	ug/ml	< 200
CHROMIUM	NEGATIVE	ug/ml	< 50

NITRITES AND CHROMATES ARE SCREENED BY COLORIMETRIC METHODS. POSITIVE RESULTS ARE CONFIRMED BY ALTERNATE METHODOLOGY. NITRITE LEVELS GREATER THAN 500 UG/ML AND/OR CHROMIUM LEVELS IN EXCESS OF 50 UG/ML ARE CONSISTENT WITH ADULTERATION.

Certified by: JOHNSTON,JADE ** FINAL REPORT **

Collected at 5078256166 MEDTOX collection site #481
PIPESTONE COUNTY MED CENTER
PIPESTONE, MN

1:00pm

ESSG Medical Referral to Employer

Employee Name: Raul Ortiz **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.

_____ 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:

ESSG
7300 Metro Blvd
Ste. 635
Edina, MN 55439
(952)835-1288
Fx: (952)835-1255

Diagnosis: allergic contact dermatitis

Treatment Plan: Medrol dosepak, Zyrtec

_____ **Non-work related**

_____ **Undetermined**

__✓__ **Work related**

RETURN TO WORK: __✓__ **With No Limitations** **Date:** 6/9/08

(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:** okay

protective

Medical Provider Signature: B Rasmussen **Date:** 6/9/08

Please fax back form to 507.562.6800 – Attn CMG/ESSG

DAVID BALT, D.O.
DEA#BB2194075

LARRY D. CHRISTENSEN, M.D.
DEA#AC7916539

GREG A. COOPER, M.D.
DEA#AC3272084

K. THEODORE DEVARAJ, M.D.
DEA#AD9747520

BRUCE W. KOCOUREK, D.O.
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DEA# MS0437435

MATT VIEL, M.D.
DEA# BV7948839

HEIDI THORESON, PA-C
DEA# MT1547833

MELISSA SCOTTING, CNP
DEA# MS1630703

PIPESTONE COUNTY MEDICAL CENTER
Pipestone Family Clinic
920 4th Avenue S.W. • Pipestone, MN 56164
507-825-5700

Name Raul Ortiz Age

Address Date 6/9/06

℞

Zyrtec 10 mg
#14
Sig: tab I po qd prn allgy

Refill 0
Label
DAW

FORM 112107

B. Ramundo

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PIPESTONE COUNTY MEDICAL CENTER
Pipestone Family Clinic
920 4th Avenue S.W. • Pipestone, MN 56164
507-825-5700

Name Raul Ortiz Age

Address Date 6/9/06

℞

Medrol 4mg dospk
#1
Sig: as directed

Refill 0
Label
DAW

FORM 112107

B. Ramundo

Report of Work Ability

See Instructions on Reverse Side

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)

RW01

DO NOT USE THIS SPACE

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
638655671	6-9-08
EMPLOYEE: Raul Ortiz	Date of Birth: 5-10-89
EMPLOYER: Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 6/9/08 (date)

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

1. [X] Employee is able to work without restrictions as of 6/9/08 (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)
BRUCE W KOCOUREK, DO
PIPESTONE COUNTY MEDICAL CENTER

ADDR 920 4TH AVE SW PIPESTONE MN 56164
507-825-5700 FAX 507-825-4744
DEA BK0472477 MN LIC 34116

CITY UPIN D25406 NPI 1699738559

SIGNATURE B. Kocourek MD

DEGREE

STATE

LICENSE #/REGISTRATION #

AREA CODE

TELEPHONE #

DATE SIGNED 6/9/08

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
638055671	6-9-08	5-10-89
EMPLOYEE: Raul Ortiz	EMPLOYER: Sutton	
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: _____ (date)

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

3. History of injury or disease given by employee:
rash p contact c fiberglass

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: 6/9/08 (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): BRUCE W KOCOUREK, DO ADDRESS: PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116 CITY: UPIN D25406 NPI 1699738559	SIGNATURE: B. Kocourek	DEGREE
	STATE	LICENSE #/REGISTRATION #
	AREA CODE / TELEPHONE #	DATE SIGNED: 6/9/08

MN HC01 (7/01).

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: Raul Ortiz Date: _____

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

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

RETURN TO WORK: X With No Limitations Date: 6/9/08

(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.)

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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: _____

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

Employee Signature: _____

Physician or Practitioner Signature: B. Ramundo

Type of Practice: (Field of Specialization) FP