



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

# Suzlon Injury Report

Team Member: Raul Ortiz

Date of Occurrence: ~~6-4-08~~ 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)

Finishing 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 sleeves shirt may help keep fiber glass off  
Employee Feedback

Raul Alfonso Ortiz  
Team Member Signature

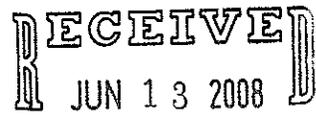
6-12-08  
Date

Manager Signature

Date

Human Resources Signature

Date





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 \_\_\_\_\_ Non-work related

\_\_\_\_\_ Undetermined

Treatment Plan: Medrol dosepak, Zyrtec \_\_\_\_\_ Work related

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.)

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: skin

Medical Provider Signature: [Signature] Date: 6/9/08

Please fax back form to 507.562.6800 - Attn CMG/ESSG

PIPESTONE COUNTY MEDICAL CENTER

Pipestone Family Clinic

920 4th Avenue S.W. • Pipestone, MN 56164

507-825-5700

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.  
DEA# BK0472477  
MICHAEL L. LASTINE, M.D.  
DEA#AL8392285  
CINDY A. SASH, PA-C  
DEA# MS0437435  
MATT VIEL, M.D.  
DEA# BV7948839  
HEIDI THORESON, PA-C  
DEA# MT1547833  
MELISSA SCOTTING, CNP  
DEA# MS1630703

Name Raul Ortiz Age \_\_\_\_\_  
Address \_\_\_\_\_ Date 6/9/08

**R**

*Zyrtec 10mg  
#14*

Refill   
Label   
DAW

*sig: tab 1 po  
qd prn atef*

FORM 112107

*B. Prunick*

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DEA# MS1630703

Name Raul Ortiz Age \_\_\_\_\_  
Address \_\_\_\_\_ Date 6/9/08

**R**

*Melrol 4mg disorb  
#1*

Refill   
Label   
DAW

*sig: as directed*

FORM 112107

*B. Prunick*

# Report of Work Ability

See Instructions on Reverse Side



R W O 1

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 <i>638655671</i>	DATE OF INJURY <i>6-9-08</i>
EMPLOYEE <i>Raul Ortiz</i>	Date of Birth <i>5-10-89</i>
EMPLOYER <i>Suzlon</i>	
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.  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 KOCUREK, DO	SIGNATURE <i>B. Kocurek</i>		DEGREE
ADDR PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744 DEA BK0472477 MN LIC 34116	STATE	LICENSE #/REGISTRATION #	
CITY UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE #	DATE SIGNED <i>6/9/08</i>

# Health Care Provider Report

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

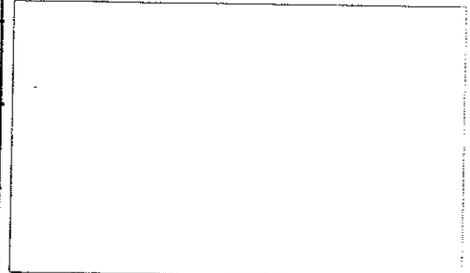


HC01

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

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER <i>638055671</i>	DATE OF INJURY <i>6-9-08</i>	DOB <i>5-10-89</i>
EMPLOYEE <i>Raul Ortiz</i>	EMPLOYER <i>Sutton</i>	
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 i 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 <i>BRUCE W KOCOUREK, DO</i> ADDRESS <i>PIESTONE COUNTY MEDICAL CENTER</i> <i>920 4TH AVE SW PIPESTONE MN 56164</i> <i>507-825-5700 FAX 507-825-4744</i> <i>DEA BK0472477 MN LIC 34116</i> CITY <i>UPIN D25406 NPI 1699738559</i>	SIGNATURE <i>B. Kocourek</i> DEGREE STATE LICENSE #/REGISTRATION # AREA CODE TELEPHONE # DATE SIGNED <i>6/9/08</i>
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# 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?  Yes  No

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

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

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\_\_\_\_\_ 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. Rasmussen

Type of Practice: (Field of Specialization) FP