SUZLON

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

Suzlon Accident Report

Team Member: Shawn Gretsch

Taken to Hospital or Clinic? Y X N___

Date of Occurrence: 5-15-08

Is This a Near Miss? Y___ N___

Time of Occurrence: 5-15-08

Date Reported: 5-16-2008

Team Leader: ______

Department: Finishing

Day shift X Night shift ___

Location of where accident occurred (*be specific*)

right hand ring finger

Description of accident / injury

possible glass or metal in hand when doing grinding or sanding

Witnesses names

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

wear rubber palm gloves

Employee Feedback

[signature]

Team Member Signature

5-16-08

Date

[signature]

Team Leader Signature

5-16-08

Date

Safety Officer Signature

Date

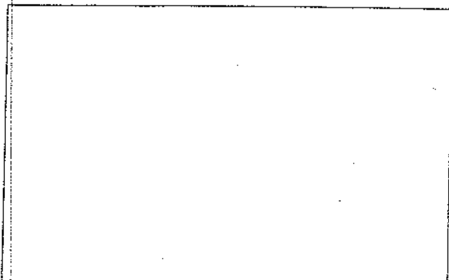
*Team Leader: Perform **Accident Investigation, Implement Corrective Action,** and submit completed form to the Safety and Environmental Officer before the end of your shift*

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
503968857	5-15-08	10-21-80
EMPLOYEE Shawn Goetsch	EMPLOYER CMG	
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: 5-16-08 (date)
2. Diagnosis (include all ICD-9-CM codes):
   staph infx Ⓛ arm + Ⓡ 4th finger
3. History of injury or disease given by employee:
   wound infection c̄ scratch @ work
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: 5/16/08 (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)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO	B-Kocourek	
ADDRESS: PIPESTONE COUNTY MEDICAL CENTER 920 4TH AVE SW PIPESTONE MN 56164 507-825-5700 FAX 507-825-4744	STATE	LICENSE #/REGISTRATION #
CITY: DEA BK0472477 MN LIC 34116 UPIN D25406 NPI 1699738559	AREA CODE	TELEPHONE # / DATE SIGNED 5/16/08

MN HC01 (7/01).

Report of Work Ability

See Instructions on Reverse Side

RW01

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	DATE OF INJURY
503 96 8857	5-15-08
EMPLOYEE: Shawn Goetsch	Date of Birth: 10-21-80
EMPLOYER: CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 5-16-08 (date)

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

1. [X] Employee is able to work without restrictions as of 5/16/08 (date)
2. [ ] Employee is able to work with restrictions, from ____ (date) to ____ (date)

   The restrictions are:

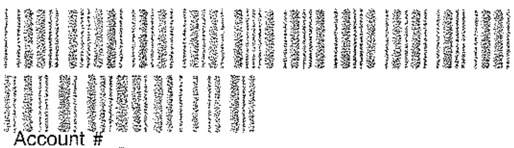
3. [ ] Employee is unable to work at all, from ____ (date) to ____ (date)

The next scheduled visit is: [X] as needed OR ____ (date)

NAME (Type or Print)	SIGNATURE	DEGREE
BRUCE W KOCOUREK, DO	B Kocourek	
ADDRESS: PIPESTONE COUNTY MEDICAL CENTER, 920 4TH AVE SW PIPESTONE MN 56164	STATE	LICENSE #/REGISTRATION #
CITY: 507-825-5700 FAX 507-825-4744, DEA BK0472477 MN LIC 34116, UPIN D25406 NPI 1699738559	AREA CODE / TELEPHONE #	DATE SIGNED: 5/16/08

MN RW01 (7/01)

3 PART DRUGS OF ABUSE TEST REQUEST



Account #

SPECIMEN ID V3859998

Employer:
SUZLON ROTOR CORPORATION
1711 S HWY 75
PIPESTONE, MN 56164

MRO:

Account # 93470

Test(s) Ordered ☒ 88343
7 PANEL

STEP 1 To be completed by **COLLECTOR / DONOR**

Social Security No, Employee No. or other Identification No.

Donor I.D. 503-96-8857

Specimen Type: ☐ Blood ☒ Urine ☐ Oral Fluid

Donor Name (last, first) or SSN: Goetsch, Shaun A.

Donor Daytime Phone: 6055538512

Referring Phys. / Company: Suzlon

DONOR CONSENT *I certify that I provided my specimen to the collector, that the specimen container was sealed with a tamper-proof seal in my presence; and that the information provided on this form and on the label affixed to the specimen bottle is correct. I authorize MEDTOX to release the results of the tests to my employer, prospective employer, employer representative and/or their authorized healthcare professionals.*

Signature [signature]

DATE Month 05 Day 02 Year 2008

STEP 2 To be Completed by **COLLECTOR**

Indicate Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion ☐ Other (specify): ☐ Return to Duty ☐ Follow-up ☒ Post Accident ☐ Periodic Medical

STEP 3 To be Completed by **COLLECTOR**

Specimen temperature must be read within 4 minutes of collection

Specimen Temperature within range: (90°-100°F/32°-38°C) ☒ YES ☐ No, Remark Required Slattery ONS,

81605

STEP 4 To be Completed by **COLLECTOR**

Collection Site Location: *Facility and Address* 481
PIPESTONE COUNTY MED CENTER
PIPESTONE, MN 56164

Collection Site Phone No. (507)825-5811

Fax No. (507)825-6081

Date and Time of Collection: Month 05 Day 02 Year 2008 (DATE); Hour 11 Minutes 45 (TIME) ☒ am ☐ pm

Remarks Concerning Collection

I, the collector, by signing below certify that the specimen identified on this form is the specimen given to me by the donor identified above and that it has been collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X Cindy Cunningham
Signature of Collector

Cindy Cunningham
(PRINT) Collector's Name (First, MI, Last)

SPECIMEN BOTTLE(S) RELEASED TO:
Name of Delivery Service Transferring Specimen to Lab
☒ DHL ☐ Local Courier
☐ Other ______

STEP 5

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