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

Incident Suzlon ~~Accident~~ Report

Team Member: Tia Preston

Taken to Hospital or Clinic? Y X N ___

Date of Occurrence: 12/27/07

Is This a Near Miss? Y ___ N X

Time of Occurrence: 7:30pm

Date Reported: 12/27/07

Team Leader: Sarah Mallak

Department: Foam room

Day shift ___ Night shift X

Location of where accident occurred (*be specific*)

In foam room

Description of accident / injury

After working in foam room for 4 hours, she noticed a rash developing on right forearm

Witnesses names

Mike Kelly

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

Took to clinic

Employee Feedback

Tia Preston — 12/27/07

Team Member Signature — Date

Brenda Zierke — 12/27/07

Team Leader Signature — 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*

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

Referral for Medical Treatment Report to Employer

Employee Name: _____ **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:

Wausau Insurance
PO Box 8016
Wausau, WI 54402

1-877-870-1542

Incomplete billings or those mailed directly to Suzlon Rotor Corporation may result in slow payment processes.

Diagnosis: allergic contact & dermatitis

Treatment Plan: oral steroid, antihistamine

____ **Non-work related**

____ **Undetermined**

__X__ **Work related**

RETURN TO WORK: ____ **With No Limitations** **Date:** 12/29/07

(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: 12/27/07 To: 12/28/07

____ **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:** use maximal protection of skin from steroids, lotrisone

Medical Provider Signature: B. Rasmussen **Date:** 12/27/07

3 PART DRUGS OF ABUSE TEST REQUEST

MEDTOX® LABORATORIES, INC.

SPECIMEN ID V8521862

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

Account #

MRO:

Account # 93470

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

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

Donor I.D. 396967642

Specimen Type: ☐ Blood ☒ Urine ☐ Oral Fluid

Donor Name (last, first) or SSN: PRESTON TIA

Donor Daytime Phone: 5072745273

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: Tia Preston

DATE Month Day Year: 12-27-2007

Test(s) Ordered: ☐ 8S343

7 PANEL

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

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)825-5511

Fax No. (507)825-5031

Date and Time of Collection: Month Day Year 12-27-2007 DATE; Hour Minutes 0845 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 Signature of Collector

(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

COPY 3 - GIVE TO SUBJECT

ENCORE UNLIMITED LLC
"The Tradition of Excellence Continues"

Website: www.encoreunlimited.com
Email: encore@encoreunlimited.com

CASE MANAGEMENT SERVICES REPORT

Insurer:	Berkley Risk Administrator	**Date of Report:**	12/28/07
Claim #:	1000023477	**Adjuster:**	Stephanie Hobot
Employee:	Tia Preston	**Seq. No. of Report:**	1
Employer:	Employer Solutions Staffing	**Case Manager:**	Judy Staples, MS, CRC
Date of Injury:	11/04/2007	**Social Security:**	N/A
Cost to Date:			

REPORT SUMMARY:

Ms. Preston was released to return to her regular duties on 12/19/07 with temporary restrictions to avoid contact with fiberglass. Ms. Preston returned to a different work area on 12/27, for approximately three hours. She reported that a rash returned on her right forearm, she was sent to ER and removed from work on 12/28. She is scheduled to see Dr. Christiansen on 12/31 at the Pipestone Clinic. Dr. Christiansen referred Ms. Preston to a dermatologist. This has been scheduled with Dr. Deaton, on 1/16/08, at the St. Peter Hospital, St. Peter, MN.

CASE MANAGEMENT PLAN:

Attend appointment with Ms. Preston on 1/16, to obtain treatment plan and return to work form. Contact all parties following appointment to provide update. Coordinate return to work with employer.

CASE ACTIVITY:

Date	*Notes*
12/17/07	Received referral information from account. Contacted insurer, employee, and employer for case information.
12/19/07	Met Ms. Preston and Dr. Christiansen at the Pipestone Clinic. I conducted an initial interview at this visit. I reviewed a Notice of Service Form with Ms. Preston explaining that I am not acting as a Qualified Rehabilitation Consultant, this form was signed by Ms. Preston. A Medical Release form was reviewed and signed for the file.
	Initial Interview:
12/19/07	Employee's account of Injury: Ms. Preston reports she developed a rash on her forearms after working with fiberglass and resin at a manufacturing plant that produces wind generator blades. She saw Dr. Christiansen who prescribed medication and removed her from work on 11/28. She states the rash initially was on her forearms, neck, and chest. Ms. Preston notes that she has improved since using the medication and being off work. Ms. Preston reports that she re-entered the plant for a short time to deliver paperwork after being released from work and the rash reoccurred on her right knee, left side and left upper thigh. I attended Ms. Preston's appointment with Dr. Christensen on 12/19/07. The doctor examined Ms. Preston's forearms, left side and right knee. He indicates the rash has cleared from the forearms and did not think rash on knee and left side were of concern. He recommended that Ms. Preston continue to use the topical medication upon returning to work. Ms. Preston was released to return to work on 12/19, with restriction to avoid fiberglass resin. Following this appointment Ms. Preston indicated she would contact her employer to provide a report of workability and obtain schedule for returning to work. She is scheduled for a recheck with Dr. Christiansen on 1/9/08, or sooner if needed. Update provided to account and RTW faxed.

12/28/07	I received a call from Ms. Preston reporting that she was seen in ER on 12/27/07 after working for approximately three hours a rash on her forearms. She indicated that she was working in a different area cutting foam. She was not using sleeve protection. The doctor in ER prescribed medication for the rash and released her to return to work on 12/29/07. Ms. Preston is scheduled to see Dr. Christiansen on 12/31/07. I notified all parties that I would be on vacation this week and Ms. Sherrill Sandell will be covering this appointment in my absence.
12/31/07	Sherrill Sandell attended appointment with Ms. Preston and Dr. Christensen. Doctor recommended she a dermatologist. Dr. Christiansen removed Ms. Preston from work until this visit has been scheduled.
1/7/08	Followed up with Ms. Preston. She states she is waiting to hear from Dr. Christensen regarding the referral for a dermatologist. I followed up with the account on the referral. The account was in the process of reviewing this and will notify me if the referral will be make with a specialist in Mankato, MN.
1/9/08	Received call from account to proceed with scheduling appointment in the Mankato area. Numerous calls to specialists in Mankato area, no appointments available until February or March. Received a call back from St. Peter Hospital indicating there was an opening on January 16th, confirmed with account. Ms. Preston is scheduled for visit on January 16, 2008 at 2:25 PM with Dr. Deaton at the St. Peter Hospital, Specialty Clinic , 507-934-7627, Hwy. 22 North, St. Peter, MN. 56082. I contacted Ms. Preston, she was not available, I left a message asking her to return my call. A message was left with Dr. Christiansen's office regarding the referral to Dr. Deaton. Information was faxed to CMG, 507-562-6800.

Enclosures:

CC:

Pipestone Medical Group
Avera
920 S.W. 4th Ave.
Pipestone, MN 56164
507-825-5750

Larry D. Christensen, M.D.
Family Medicine
DEA No. AC7816539

For Tia Preston Date 12-31-07

See Dermatologist

Repetatur
☐Non Repetatur
☐DAW

Dr. L D Christensen

Instructions On Back

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
396967642	11-28-07
EMPLOYEE: Tim M. Preston	Date of Birth: 11-4-80
EMPLOYER: CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 12-31-07 (date)

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

1. ☐ Employee is able to work without restrictions as of _____ (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 12-31-07 (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____ (date)

P dermatologist

NAME (Type or Print)	SIGNATURE	DEGREE
ADDR: LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 FAX 507-825-4744 DEA-AC7916539 MN LISC-23799 UPIN D75623		MD
CITY	STATE / LICENSE #/REGISTRATION #	
	AREA CODE / TELEPHONE #	DATE SIGNED: 12-31-07

MN RW01 (7/01)

PIPESTONE COUNTY MEDICAL CENTER/Avera Health
Pipestone, MN

ACCT#: H0246301 ADM STATUS: DEP ER
MR#: H046763 DOB: 11/04/80
PRESTON,TIA
ADM/SERV DATE: 12/27/07
ATTEND PHY: KOCOUREK,BRUCE W., DO
DICT PHY: KOCOUREK,BRUCE W., DO

ER visit

EMERGENCY ROOM REPORT

Date of Service: 12/27/07

S: The 27-year-old Caucasian female presents to the ED with a complaint of rash. Has apparently had a recurrent rash from contact and exposure at her work place at Suzlon. The patient has been off work the past three weeks. Has been treated with several topical and some oral steroids for the rash. Finally got rid of the rash, returned to work today for the first time and developed rash again about the forearm, which is itching. She has changed jobs. Has been out of the mold away from the plastic and resins. Has been doing some other cutting and even today developed a rash about the forearms. The patient did not have long sleeves on or other skin protection.

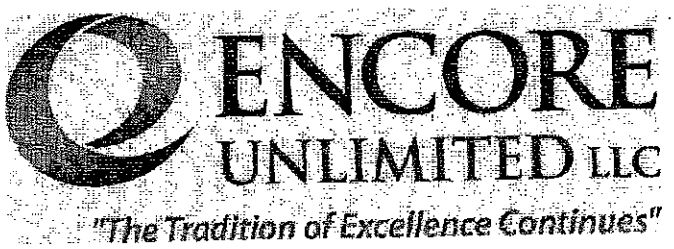
O: Heart is RRR. Lungs are clear to auscultation. Examination of the skin reveals reddened latticework slightly raised itching rash noted from the base of the palms proximally to just above the elbows in exposed area of the skin of a short sleeve shirt. No areas of irritation about the neck or facial area. No leg irritation or rash noted.

A: 1. Allergic contact dermatitis.

P: 1. Will go ahead and place on a Medrol 4 mg dose pack to be used as directed. Will place on Benadryl 25 mg tabs, 2 tabs q. 4-6 hours as needed for itch to get through tonight. Will place on Zyrtec 10 mg 1 tab PO q. daily following that. Will continue avoidance at work. Wear long sleeve shirts, gloves and other protection as possible. If she continues to have a recurrent rash just from airborne or contact at work she may need to consider different employment. Will have her avoid plastics, resins, and other chemicals as possible at work with maximal skin protection. Will allow to return to work on 12/29/2007.

KOCOUREK,BRUCE W., DO

D: 12/27/07 T:12/28/07 LKB 1228-0054
Dict. Phy. cc: KOCOUREK,BRUCE W., DO
cc:
This report to:



Mankato, MN. 56001
Phone:507-345-1922
Fax: 507-345-1956
jstaples@encoreunlimited.com

FAX COVER SHEET

Date:	1/9/08
Total Pages Including This Page:	6

RE:	Tia Preston

To:	CMG - Work Comp
Fax Number:	507-562-6800
From:	**Judy Staples,** QRC #679

This facsimile document may contain sensitive, privileged, or confidential information that belongs to the sender. If you are not the intended recipient, please do not copy, distribute, or disclose this document to anyone other than the person listed above. If you received this facsimile in error, please notify us at 800-898-3631 as soon as possible and return the original message by mail to the address listed above. Thank you.

Please call if you have any questions

Thanks. Judy Staples

www.encoreunlimited.com
ENCORE UNLIMITED LLC
JUDY STAPLES, MS, CRC
Disability Case Manager
Territory: Mankato/Southern Minnesota
2345 Rice Street, Suite 223 • Roseville, MN 55113-3723
Phone: 507-345-1922 or 800-898-3631 • Fax: 507-345-1956
jstaples@encoreunlimited.com
"The Tradition of Excellence Continues"

If you do not receive all of the pages, please contact us as soon as possible. Thank you.

Encore Unlimited, LLC
The Tradition of Excellence Continues

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
396967642	11-28-07
EMPLOYEE: Tia M. Preston	Date of Birth: 11-4-80
EMPLOYER: CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office _____ (date)

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

1. ☐ Employee is able to work without restrictions as of _____ (date)

2. ☒ Employee is able to work with restrictions, from 12-19-07 (date) to _____ (date)

The restrictions are:

Avoid contact with Fiberglass Resin

3. ☐ Employee is unable to work at all, from _____ (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____ (date) 3 weeks

NAME (Type or Print)	SIGNATURE	DEGREE
ADDRESS: LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 FAX 507-825-4744 DEA-AC7916539 MN LISC-23799 UPIN D75623		MD
CITY	STATE / LICENSE #/REGISTRATION #	
	AREA CODE / TELEPHONE #	DATE SIGNED: 12-19-07

MN RW01 (7/01)

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
396967642	11-28-07
EMPLOYEE: Tia M. Preston	Date of Birth: 11-4-80
EMPLOYER: CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 12-12-07 (date)

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

1. ☐ Employee is able to work without restrictions as of _____ (date)

2. ☐ Employee is able to work with restrictions, from _____ (date) to _____ (date)

The restrictions are:

Wore gloves & tne sleeves

3. ☒ Employee is unable to work at all, from 12-12-07 (date) to 12-19-07 (date)

The next scheduled visit is: ☐ as needed OR _____ (date) 1 wk

NAME (Type or Print)	SIGNATURE	DEGREE
ADDRESS: LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 FAX 507-825-4744 DEA-AC7916539 MN LISC-23799 UPIN D75623		MD
CITY	STATE / LICENSE #/REGISTRATION #	
	AREA CODE / TELEPHONE #	DATE SIGNED: 12-12-07

MN RW01 (7/01)

RX THIRD PARTY SOLUTIONS
P O BOX 17124 Memphis, TN 38187-0124

01827 3716333 003028 003028 00002/00002

INVOICE

PLEASE INCLUDE INVOICE NUMBER ON PAYMENT BENEFITS ASSIGNED

Invoice No. 23983776
Invoice Date 12/09/07
~~396967642~~
Claimant PRESTON TIA
Address 427 SIERRA AVE
WESTBROOK, MN 56183
SS# 396-96-7642
Employer SUZLON ROTOR CORPORATION
Address 1711 S US HIGHWAY 75
PIPESTONE, MN 56164-1697
Carrier/Claim File
Injury Date 11/28/07
NCPDP 2414112 SNYDER DRUG
PIPESTONE,MN 56164
NPI # 1174604607

SUZLON ROTOR CORPORATION
1711 S US HIGHWAY 75
PIPESTONE MN 56164-1697

Workers Compensation Claim

Date of Service	RX #	Description	Quantity	Unit	Dr. Name		Amount Due
11/28/07	0668759	NDC# 00781502201 METHYLPRED TAB 4MG	42.000	EA	AC7916539 CHRISTENSEN L 7 day supply (G) New		34.29
11/28/07	0668760	NDC# 00168000416 TRIAMCINOLON CRE 0.1%	60.000	GM	AC7916539 CHRISTENSEN L 10 day supply (G) New		8.20
11/28/07	0668761	NDC# 49348037508 SM ALLERGY TAB 25MG RLF	48.000	EA	AC7916539 CHRISTENSEN L 6 day supply (G) New		9.93

REMIT PAYMENT TO:
P. O. BOX 1000, DEPT., #492
MEMPHIS, TN 38148-0492
(901) 681-9080 800-541-5234

FULL AMOUNT DUE UPON RECEIPT
PRICING CONFORMS TO STATE FEE SCHEDULE
PAYMENT REDUCTION NOT AUTHORIZED

THIRD PARTY SOLUTIONS PROCESSES PRESCRIPTIONS FROM PHARMACIES

Total Amount Due	52.42

FEDERAL TAX I.D. 62-1770924

THIRD PARTY SOLUTIONS, INC.
PO BOX 17124
MEMPHIS TN 38187-0124

01827 3716333 003027 003027 00001/00002

Forwarding Service Requested

>01827 3716333 001 092013
SUZLON ROTOR CORPORATION
ATTN: WORKERS COMPENSATION DEPT
1711 S US HIGHWAY 75
PIPESTONE MN 561641697

Number of Documents: 000001

Eileen Stephenson

From: Sarah [sarah@corpmgmtgroup.com]
Sent: Wednesday, December 05, 2007 9:01 AM
To: bzinnel@suzlonrotor.com; jboone@suzlonrotor.com
Cc: 'Eileen Stephenson'; 'Ashley Postma'
Subject: work comp

Good Morning,

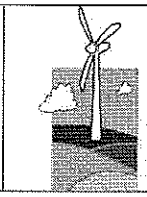
Tia Preston: Mould, Night Shift

I had a call for a work comp on 11/28/07 with a breakout of a rash.

I just need a verification that this happened that would be great.

Thanks,

Sarah Evans
Recruiter
CMG
(507)562-6712
sarah@corpmgmtgroup.com



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

Referral for Medical Treatment Report to Employer

Employee Name: Tia Preston **Date of Injury:** 11-28-07

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.

Tia Preston
Employee Signature

11-28-07
Date

Medical Provider KD Christensen **Date / Time of Appt:** 11-28-07 4:00pm

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:

Wausau Insurance
PO Box 8016
Wausau, WI 54402

1-877-870-1542

Incomplete billings or those mailed directly to Suzlon Rotor Corporation may result in slow payment processes.

Diagnosis: Dermatitis

Treatment Plan: Meds

_____ **Non-work related**

_____ **Undetermined**

_____ **Work related**

RETURN TO WORK: _____ **With No Limitations** **Date:** _____

(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: 1 week **Provider's Comments:** _____

Medical Provider Signature: KD Christensen MD **Date:** 11-28-07

3 PART DRUGS OF ABUSE TEST REQUEST

MEDTOX® LABORATORIES, INC.

SPECIMEN ID U8521886

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

Account #

MRO:

Account # 93470

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

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

Donor I.D. 396967642

Specimen Type: ☐ Blood ☒ Urine ☐ Oral Fluid

Donor Name (last, first) or SSN: Areston Tia

Donor Daytime Phone: 5072745273

Referring Phys. / Company

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: Tia Preston

DATE: Month 11 Day 28 Year 2007

Test(s) Ordered: X 8854 3 PANEL

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

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 11 Day 28 Year 2007 (DATE); Hour 1620 Minutes (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

11-28-07

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
PRESTON,TIA

PATIENT I.D. NO. V8521886
AGE
SEX
SPECIMEN H4778879

396-96-7642

DATE COLLECTED	TIME COLLECTED	DATE RECEIVED	DATE REPORTED
11/28/2007	16:20	11/29/2007	11/29/2007 11:40AM

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	146.1	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: NORRIS,JANE ** FINAL REPORT **

Collected at 5078255811 MEDTOX collection site #481
PIPESTONE COUNTY MED CENTER
PIPESTONE, MN

Report of Work Ability

See Instructions on Reverse Side

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

RW01

DO NOT USE THIS SPACE

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
396967642	11-28-07
EMPLOYEE: Tia M. Preston	Date of Birth: 11-4-80
EMPLOYER: CMG	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 12-5-07 (date)

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

1. ☐ Employee is able to work without restrictions as of _____ (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 12-5-07 (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____ (date) 1 week

NAME (Type or Print)	SIGNATURE	DEGREE
ADDRES: LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP 920 4TH AVE SW PIPESTONE, MN 56164 507-825-5700 FAX 507-825-4744 DEA-AC7916539 MN LISC-23799 UPIN D75623	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE / TELEPHONE #	DATE SIGNED: 12-5-07

MN RW01 (7/01)

Report of Work Ability

See Instructions on Reverse Side

Please PRINT or TYPE your responses.
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SOCIAL SECURITY NUMBER	DATE OF INJURY
396967642	
EMPLOYEE: Tia M. Preston	Date of Birth: 11-4-80
EMPLOYER: Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 11-28-07 (date)

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

1. ☐ Employee is able to work without restrictions as of _____ (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 11-28-07 (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____ (date) 1 week

NAME (Type or Print)

LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP

ADDRESS 920 4TH AVE SW PIPESTONE, MN 56164
507-825-5700 FAX 507-825-4744
DEA-AC7916539 MN LISC-23799 UPIN D75623

CITY

STATE

SIGNATURE

DEGREE MD

LICENSE #/REGISTRATION #

AREA CODE

TELEPHONE #

DATE SIGNED 11-28-07

RW01 (7/01)