



Suzlon Accident Report

~~ESTG~~
CMG

Team Member: Travis Come

Taken to Hospital or Clinic? Y__ N__

Date of Occurrence: Dec 27 07

Is This a Near Miss? Y__ N__

Time of Occurrence: 11:30 pm

Date Reported: Dec 28 07

Team Leader: TJendra

Department: Quality

Day shift __ Night shift

Location of where accident occurred (be specific)

In Mould Area - Blue Line - PASTA on arm's
Broke out in rash
Description of accident / injury
Failure of PPR, PASTA GOT ON ARM'S

Witnesses names

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

Employee Feedback

Travis Come
Team Member Signature

28/Dec 07
Date

TJendra
Team Leader Signature

12/28/07
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

ESSG

Employee Name: Travis Comer

Date of Injury: Dec 27

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.

Travis L Comer
Employee Signature

Dec 28 07
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: Dematomyelitis _____ Non-work related

_____ Undetermined

Treatment Plan: _____ 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: _____ Provider's Comments: _____

Medical Provider Signature: [Signature] Date: 12-28-07

T DRUGS OF ABUSE TEST REQUEST



SPECIMEN ID V8521865

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



Account #

1 To be completed by COLLECTOR / DONOR

Social Security No, Employee No. or other Identification No. Donor I.D. 520843490

Specimen Type: Blood Urine Oral Fluid

Donor Name (last, first) or SSN COMER TRAVIS

Donor Daytime Phone 6515871605 Referring Phys. / Company Suzlon

MRO:

Account # 93470

Test(s) Ordered 88543



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 12-28-07

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

3 To be Completed by COLLECTOR

Specimen temperature must be read within 4 minutes of collection: YES No, Remark Required

Specimen Temperature within range: (90°-100°F/32°-38°C) **81605**

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: 12-28-07 17:00 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.

[Signature]
Signature of Collector
Debra A. Grootwassink
(PRINT) Collector's Name (First, MI, Last)

SPECIMEN BOTTLE(S) RELEASED TO:

Name of Delivery Service Transferring Specimen to Lab: DHL Local Courier Other _____

5



12 28 07

Copyright Medtox 1999



PO BOX 17124 Memphis, TN 38187-0124

INVOICE

**PLEASE INCLUDE
INVOICE NUMBER ON PAYMENT
BENEFITS ASSIGNED**



>01133 3770814 001 092013
CORPORATE MANAGEMENT GROUP
1711 S US HIGHWAY 75
PIPESTONE MN 56164-1697



Invoice No. 24274051
Invoice Date 01/09/08
520843490
Claimant COMER TRAVIS
Address 617 2ND AVE NE
PIPESTONE, MN 56164
SS# 520-84-3490
Employer CORPORATE MANAGEMENT
GROUP
Address 1711 S US HIGHWAY 75
PIPESTONE, MN 56164-1697
Carrier/Claim File E
Injury Date 12/27/07
NCPDP 2411306 A & S DRUG
PIPESTONE, MN 56164

Workers Compensation Claim

Date of Service	RX #	Description	Quantity	Unit	Dr. Name	Amount Due
12/28/07	0627441	NDC# 16500002324 DOMEBORO POW PACKETS #12 (MF)	12.000	EA	AL8392285 LASTINE MICHA 6 day supply (B) New	13.88
12/28/07	0627442	NDC# 50111030802 HYDROXYZ HCL TAB 25MG	30.000	EA	AL8392285 LASTINE MICHA 10 day supply (G) New	30.66
12/28/07	0627443	NDC# 51672127003 DESOXIMETAS CRE 0.25%	60.000	GM	AL8392285 LASTINE MICHA 5 day supply (G) New	104.03

New Remit to: 24274051

REMIT PAYMENT TO:
P.O. BOX 504591
ST. LOUIS, MO 63150-4591
(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	148.57
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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 # 520-84-3490		2. OSHA Case #	
3. DATE OF CLAIMED INJURY 12/27/2007		4. Time of injury 11:30 <input type="checkbox"/> am <input checked="" type="checkbox"/> pm	5. Time employee began work on date of injury 03:30 <input type="checkbox"/> am <input checked="" type="checkbox"/> pm
6. EMPLOYEE Name (last, first, middle) Comer Travis		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 617 2nd Ave NE City: Pipestone State: MN Zip Code: 56164		10. Home phone # (651) 587-1605	11. Date of birth 6/24/1970
12. Occupation Production Worker		13. Regular department Quality	
14. Date hired 12/24/2007	15. Average weekly wage \$424.00	16. Rate per hour \$10.60	17. Hours per day 8
18. Days per week 6	19. Employment Status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Seasonal <input type="checkbox"/> Part time <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." Failure of PPR, pasta got on arms and broke out in a rash.	
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 arms		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard pasta, resin	
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 12/27/2007	29. Date employer notified of lost time
		30. Return to work date 12/28/2007	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 City: THORNTON State: CO Zip Code: 80241		39. Employer FEIN	40. Unemployment ID # 0036373110
41. Employer's contact name and phone # Amanda Carnahan (303) 920-1425		42. Physical address (if different)	
43. Witness (name and phone) n/a		44. NAICS code	
45. Date form completed 04/25/2008		46. INSURER name MINNESOTA ASSIGNED RISK PLAN	
47. Insured legal name		51. CLAIMS ADMIN COMPANY (CA) name (check one) Insurer TPA Berkley Risk Administrators Company, LLC	
48. Policy # or self-insured certificate #		52. CA Address 222 South Ninth Street City: Minneapolis State: MN Zip Code: 55402	
49. Insurer FEIN	50. Date insurer received notice 04/25/2008	53. CA FEIN 41-1887666	54. Claim # 04 - 188602 -

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 Travis Comer COMPANY CORPORATE MANAGEM DEPT. Quality

DATE OF ACCIDENT 12/27/2007 TIME 11:30 PM DID EMPLOYEE LOSE TIME FROM WORK? YES NO

HOURS LOST ON DATE OF ACCIDENT _____ HAS EMPLOYEE RETURNED TO WORK? YES NO

JOB TITLE Production Worker SERVICE WITH THE COMPANY 1 mo YEARS IN PRESENT JOB 1 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.) Failure of PPR, pasta got on arms and broke out in a rash.

WITNESSES' NAMES n/a

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?)

N/A

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 12/28/2007

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 at work and working with material of the job.

REPORT SUBMITTED BY Ashley Postma

DATE 04/25/2008

Administrative Assistant