SUZLON

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

CMG

Suzlon Injury Report

4-15-2008
160
CMG copied 4-16

Team Member: Will Clipp

Date of Occurrence: 4/14/08

Time of Occurrence: ~~Unknown~~ 6PM

Department: Finishing (Yard)

Team Leader: Guy Leech

Date Reported: 4/15/08

If taken to Doctor, fill out this section

Date of Treatment: 4-16-2008

Time of Treatment: 8:30

Doctor: Dr. Konarak

Drug Test Performed: Yes No

Drug test date & time:

Location of where accident occurred (*be specific*)

Working outside in yard.

Description of accident / injury

Pain in right shoulder area. Difficult to lift arm without causing pain. Unkown cause. Noticed pain ~~after working work~~ at about 6PM while lifting root stands, loading blades for shipment.

Witnesses names

~~Non~~ none

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

Investigate a different procedure to rotate blades for shipment without having to manually lift root stands.

Employee Feedback

Will Clipp — 4-15-08

Team Member Signature — Date

Manager Signature — 15Apr08

Date

Thomas Funk — 4-15-2008

Human Resources Signature — Date

RECEIVED
APR 16 2008
BY:

F:SF:03 Rev Num:1 Rev Date: 23-AUG-2006

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.

FRO1

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA Case #
460-85-6872	

3. DATE OF CLAIMED INJURY	4. Time of injury		5. Time employee began work on date of injury	
4/14/2008	06:00	☐ am ☑ pm	07:00	☑ am ☐ pm

6. EMPLOYEE Name (last, first, middle)	7. Gender	8. Marital Status
Clipp William	☑ M ☐ F	☐ Married ☑ Unmarried

9. Home address	10. Home phone #	11. Date of birth
338 W. Okabena Street	(979) 219-8115	4/4/1979

City	State	Zip Code	12. Occupation	13. Regular department	14. Date hired
Worthington	MN	56187	Production Worker	Finishing	2/13/2008

15. Average weekly wage	16. Rate per hour	17. Hours per day	18. Days per week	19. Employment Status		
$400.00	$10.00	8	6	☑ Full time ☐ Seasonal	☐ Part time ☐ Volunteer	

20. Weekly value of:	Meals	Lodging	2nd income	21. Apprentice	
	$0.00	$0.00	$0.00	☐ Yes	☑ 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."*

Pain in right should area. Difficult to lift arm without causing pain. Unknown cause. Noticed pain about 6 pm while lifing root stands, loading blades for shipment.

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*	24. What tools, equipment, machines, objects, or substances were involved? *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*
right shoulder	roots, blade

25. Did injury occur on employer's premises? ☑ Yes ☐ 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) ☐ Yes ☐ No ☑ No lost time on DOI
	28. Date employer notified of injury 4/14/2008	29. Date employer notified of lost time
	30. Return to work date 4/14/2008	31. Date of death

32. TREATING PHYSICIAN (name, address, and phone)	33. HOSPITAL/CLINIC (name and address) (if any)	34. Emergency Room Visit	35. Overnight in-patient
Dr. Koucerik 920 4th Ave SW Pipestone MN 56164 507-825-5700	Pipestone Medical Group 920 4th Ave SW Pipestone MN 56164	☑ Yes ☐ No	☐ Yes ☑ No

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
CORPORATE MANAGEMENT GROUP INC 188602		
38. **Mailing** address 12000 N. WASHINGTON ST. #290	39. Employer FEIN	40. Unemployment ID # 0036373110
City: THORNTON State: CO Zip Code: 80241	41. Employer's contact name and phone # Amanda Carnahan (303) 920-1425	
42. **Physical** address (if different)	43. Witness (name and phone)	
City State Zip Code	44. NAICS code	45. Date form completed 04/16/2008

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY** (CA) name (check one)	Insurer / TPA
MINNESOTA ASSIGNED RISK PLAN	Berkley Risk Administrators Company, LLC	
47. Insured legal name	52. CA Address 222 South Ninth Street	
48. Policy # or self-insured certificate #	City: Minneapolis State: MN Zip Code: 55402	
49. Insurer FEIN	50. Date insurer received notice 04/16/2008	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 William Clipp COMPANY CORPORATE MANAGEM DEPT. Finishing

DATE OF ACCIDENT 4/14/2008 TIME 6:00 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 4 mo YEARS IN PRESENT JOB 4 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 ☑	NO ☐
2.	DID INJURED PERSON VIOLATE ANY INSTRUCTIONS?	NO ☑	YES ☐
3.	WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE)	YES ☑	NO ☐
4.	DID POOR HOUSEKEEPING CONTRIBUTE TO INJURY?	NO ☑	YES ☐
5.	DID HORSEPLAY CAUSE THE INJURY?	NO ☑	YES ☐
6.	WAS IT CAUSED BY SOMETHING WHICH NEEDED REPAIRS?	NO ☑	YES ☐
7.	SHOULD A GUARD BE PROVIDED?	NO ☑	YES ☐
8.	DID ANY BODILY DEFECT CONTRIBUTE TO INJURY?	NO ☑	YES ☐
9.	WAS IT CAUSED BY AN UNSAFE ACT?	NO ☑	YES ☐
10.	DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY?	YES ☑	NO ☐

ACCIDENT. (DESCRIBE WHAT INJURED WAS DOING AT TIME OF ACCIDENT, WHAT HAPPENED, WHO WAS INVOLVED, NATURE OF INJURY, PART OF BODY AFFECTED.) Pain in right should area. Difficult to lift arm without causing pain. Unknown cause. Noticed pain about 6 pm while lifing root stands, loading blades for shipment.

WITNESSES' NAMES _____

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?)

Investigate a different procedure to rotate blades for shipment without having to manually lift root stands.

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 Dr. Koucerik DATE OF INITIAL VISIT 04/14/2008

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.

REPORT SUBMITTED BY Ashley Postma DATE 04/16/2008

Administrative Assistant

BRAC 2520 (10/99)