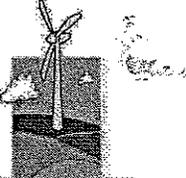


 <p>SUZLON</p>		<h2>Suzlon Injury Report</h2>
<p>S.R.C. - Pipestone, MN U.S.A.</p>		

Team Member: Zachary Like
 Date of Occurrence: 5-24th-07
 Time of Occurrence: 6:00 pm
 Department: Material prep/resin tech
 Team Leader: _____
 Date Reported: 5-25-07

If taken to Doctor, fill out this section
 Date of Treatment: _____
 Time of Treatment: _____
 Doctor: _____
 Drug Test Performed: Yes No
 Drug test date & time: _____

Location of where accident occurred (be specific)
In front of resin room

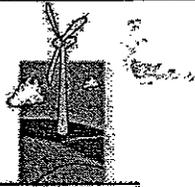
Description of accident / injury
I was cleaning up a resin spill and slipped on the edge of the trench and my foot fell into the resin causing a burn on top of foot and ankle.

Witnesses names
Jared Bansemer Matt Hess

Corrective action (include: task, equipment, environmental, and management factors) – If needs further investigation use form F:ST:02
use rubber boots for cleaning resin spills

Employee Feedback

<u>[Signature]</u> Team Member Signature	<u>6-1-07</u> Date
<u>[Signature]</u> Team Leader Signature	<u>1-June-07</u> Date
Human Resources Signature	Date



Suzlon Injury Report

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

Team Member: Zachary Like

If taken to Doctor, fill out this section

Date of Occurrence: 5-24-07

Date of Treatment: _____

Time of Occurrence: 6:00pm

Time of Treatment: _____

Department: Material prep/resin tech

Doctor: _____

Team Leader: _____

Drug Test Performed: Yes No

Date Reported: 5-25-07

Drug test date & time: _____

Location of where accident occurred (be specific)

In front of resin room

Description of accident / injury

I was cleaning up a resin spill and slipped on the edge of the trench and my foot fell into the resin causing a burn on top of foot and ankle.

Witnesses names

Jared Bansemer Matt Hess

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

use rubber boots for cleaning resin spills

Employee Feedback

[Signature]

Team Member Signature

6-1-07

Date

[Signature]

Team Leader Signature

1-June-07

Date

Human Resources Signature

Date

Claim Reference Number 0000403849I for Zachary Like Successfully Transmitted

It has been initially assigned to the following
AIG Claim Services Office:

021 - WC LANSING, MI
AIG Claim Services
P.O. Box 1830
Alpharetta, GA 30023-3030
Tel.(866) 642-5246
WCATLFROI@aig.com

You may wish to use the 'Print' button below to
make a copy of this page for your records.

If you would like to print an FROI form, please
click [here](#) .

In the near future, a formal notification letter will
be forwarded verifying receipt of this claim.

If you have a claim related question, please contact the handling office listed above directly.

For Internet-related questions contact the AIG Support Network at 1-800-767-2524 or email the
Application Support Group at TeleClaimSupport@AIG.com.
Please use this contact information for technical questions only.

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MURRAY COUNTY CLINIC OCCUPATIONAL HEALTH AND WELLNESS

EMPLOYER
EMPLOYEE
PHYSICIAN
COMPLETE

Authorization for medical care
 Employee Name * Zachary Paul Like SS# * 472-19-1103 Date 5/21/07 Time _____ AM/PM
 Address 13495 Clayton St. Phone # 507-562-6713
 Company Name Corporate Management Group Inc Supervisor Jessica - Pam Smith

Date of injury 5/16/07 Time 9:00 AM/PM
 Description of injury/illness Cleaning up a resin spill and the resin soaked through my shoe and burnt my foot

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Occupational Health to release or receive any information including the diagnosis and records of any treatment or examination resulting from this injury to my employer and/or health care provider.
 Signature: X [Signature] Date: 5/21/07

Diagnosis: chemical burn to R foot
 Treatment: steroids to decrease swelling, benadryl by mouth
 Able to work: regular duties duties
 Unable to work until needs to wear open shoes or flip flops on R
 Able to return to work with the following restrictions: cannot wear shoes on R foot

- Restricted lifting (maximum weight in pounds)
 - 10 20 30 40 50 60
- Restricted pushing/pulling of _____ lbs.
- Restricted reaching above chest overhead rt hand lt hand
- Restricted to one-handed duty. NO use of rt hand lt hand
- Primarily sitting duty with occasional walking/standing
- Restricted walking Restricted crawling Restricted kneeling
- Restricted standing Restricted sitting Restricted driving
- Restricted squatting
- Non weight-bearing use crutches _____
- Partial weight-bearing (as tolerated)
- No repetitive movement of

Right	Left
<input type="checkbox"/> hand grasp	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> wrist	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> elbow flexion	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> shoulder	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> foot	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> ankle	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> hip	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> back	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> neck	<input type="checkbox"/> <input type="checkbox"/>

DO NOT
<input type="checkbox"/> Operate machinery/equipment
<input type="checkbox"/> Drive any vehicle
DO
<input checked="" type="checkbox"/> Take medication as directed
<input type="checkbox"/> Ice and elevate
<input type="checkbox"/> Wear splint: <input type="checkbox"/> all the time
<input type="checkbox"/> work
<input type="checkbox"/> night
<input type="checkbox"/> Use warm compresses

Other Restrictions: _____
 Provider Signature: [Signature] Date _____ Time Out _____

Follow up visit DATE 10 days - 2 wks TIME _____ Discharge from Care
 Referral to physical therapy Yes No Return as needed.
 Referral to _____ Frequency _____
 Report called to _____ Date _____ Time _____