



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

Referral for Medical Treatment Report to Employer

Employee Name: Austin Kelly 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.

Austin Kelly 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: Resin Toxicity _____ Non-work related
_____ Undetermined
Treatment Plan: drop _____ Work related

RETURN TO WORK: With No Limitations Date: 12-3-07
(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: _____ 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: X _____ Provider's Comments: _____

Medical Provider Signature: [Signature] Date: 12-3-07



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

Suzlon Accident Report

04-188602
Claim #

Team Member: Austin Kelly

Taken to Hospital or Clinic? Y N

Date of Occurrence: 11-06-2007

Is This a Near Miss? Y N

Time of Occurrence: _____

Date Reported: 11-07-2007

Team Leader: Lee Gorter / Jason Fraser

Department: Facility Maintenance

Day shift Night shift Parttime
1230-430

COPY

Location of where accident occurred (be specific)

Resin Mixing Room EastPod Bldg A

Description of accident / injury

- While performing a clean up of a Resin/Hardener Spill that was contained in the Containment Trays the Fumes of the Chemicals Caused him to feel ill and leave early, morning of the 7th he went to the Pipestone Clinic.

Witnesses names

Lee Gorter

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

- Respirators need to be worn when cleaning large Amounts of Spilled/Contained Chemicals.

Employee Feedback

Throat irritation persists - unable to work until further notice.
11/07

Team Member Signature

[Signature]

Date

11-08-07

Team Leader Signature

[Signature]

Date

11-28-07

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)



H C 0 1

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER <i>627280323</i>	DATE OF INJURY <i>11-7-07</i>	DOB <i>7-19-89</i>
EMPLOYEE <i>Austin Kelley</i>	EMPLOYER <i>Suzlon Rotor</i>	
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: *11-8-07* (date)
2. Diagnosis (include all ICD-9-CM codes):
was cleaning up a Resin spill - started coughing, vomiting & H/A
3. History of injury or disease given by employee:
Resin toxicity
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: *12-3-07* (date)
9. Has the employee reached maximum medical improvement? (If yes, complete item #10) (See definition on back) No Yes Date reached: *12-3-07*
10. Has the employee sustained any permanent partial disability from the injury? No Yes Too early to determine
The permanent partial disability is *0* % of the whole body. This rating is based on Minn. Rules:

5223.	%	5223.	%
5223.	%	5223.	%

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

Report of Work Ability

See Instructions on Reverse Side



R W 0 1

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 <i>627 280 323</i>	DATE OF INJURY <i>11-7-07</i>
EMPLOYEE <i>Austin Kelley</i>	Date of Birth <i>7-19-89</i>
EMPLOYER <i>Suzlon Rotor</i>	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office *12-3-07* (date)

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

1. Employee is able to work without restrictions as of *12-3-07* (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: as needed OR _____ (date)

NAME (Type or Print)	SIGNATURE <i>Larry D Christensen</i>		DEGREE <i>MD</i>
ADDRESS: <i>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</i>	STATE	LICENSE #/REGISTRATION #	
CITY	AREA CODE	TELEPHONE #	DATE SIGNED <i>12-3-07</i>

Report of Work Ability

See Instructions on Reverse Side



R W 0 1

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 12/4/07
EMPLOYEE Suzlon Bruce Komula	Date of Birth 10/3/87
EMPLOYER Suzlon	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office

12/6/07	(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 12-6-07 (date) to (date)

The restrictions are:

<p>Avoid activity that causes left knee pain</p>
--

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

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

Wk

NAME (Type or Print) LARRY D CHRISTENSEN, MD PIPESTONE MEDICAL GROUP	SIGNATURE <i>Larry D Christensen</i>	DEGREE MD
ADDRESS 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 12-06-07