REPRINTED ON 11/28/2007

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

SUZLONROTOR
627-28-0323

PATIENT NAME
AUSTIN,KELLY

PATIENT I.D. NO. V8521870
AGE
SEX
SPECIMEN H4670858

	DATE COLLECTED	TIME COLLECTED	DATE RECEIVED	DATE REPORTED
				10:35AM
	11/14/2007	15:50	11/15/2007	11/15/2007

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	134.8	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: PHAN,VAN ** FINAL REPORT **

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

SUZLON

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

Referral for Medical Treatment Report to Employer

Employee Name: Austin Kelley **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: Resin Toxicity

_____ **Non-work related**

_____ **Undetermined**

Treatment Plan: dong

_____ **Work related**

RETURN TO WORK: X **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: _____ **Date:** 12-3-07

Health Care Provider Report

See Instructions on Reverse Side
(WHEN COMPLETED RETURN TO REQUESTER)

HC01

DO NOT USE THIS SPACE

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

SOCIAL SECURITY NUMBER	DATE OF INJURY	DOB
627280323	11-7-07	7-8-89
EMPLOYEE: Austin Kelley	EMPLOYER: Suzlon Rotor	
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	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	STATE / LICENSE #/REGISTRATION #	
CITY	AREA CODE / TELEPHONE #	DATE SIGNED

MN HC01 (7/01).

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
627 280 323	11-7-07
EMPLOYEE: Austin Kelley	Date of Birth: 7-19-89
EMPLOYER: Suzlon Rotor	
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. [X] 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: [X] as needed OR _____ (date)

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	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE / TELEPHONE #	DATE SIGNED: 12-3-07

MN RW01 (7/01)

SUZLON

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

Suzlon Accident Report

COPY

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 Carter / Jason Fraser

Department: Facility Maintenance **Day shift** ___ **Night shift** ___ Part time X 1230-430

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/Hardner Spill that was contained in the Containment Trays the Fumes of the Chemicals Caused him to feel ill and leave early, Making of the 7th ~~he~~ he went to the Pipestone Clinic.

Witnesses names

Lee Carter

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	**Date**
Team Leader Signature	**Date** 11-28-07
Safety Officer Signature	**Date** 11-28-07

*Team Leader: Perform **Accident Investigation, Implement Corrective Action,** and submit completed form to the Safety and Environmental Officer before the end of your shift*

Report of Work Ability

See Instructions on Reverse Side

RWO 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. 8)

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
627 280 323	11-7-07
EMPLOYEE: Austin Kelley	Date of Birth: 7-19-89
EMPLOYER: Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 11-12-07 (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 11-12-07 (date) to (date)

The restrictions are:

Stay out of rooms that have higher concentrations of Resin & Fiberglass dusts

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

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

NAME (Type or Print)	SIGNATURE	DEGREE
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
ADDRESS	STATE	LICENSE #/REGISTRATION #
CITY	AREA CODE / TELEPHONE #	DATE SIGNED 11-12-07

MN RWO 1 (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. 8)

RWO 1

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
627 280 323	11-7-07
EMPLOYEE: Austin Kelley	Date of Birth: 7-19-89
EMPLOYER: Suzlon Rotor	
INSURER/SELF-INSURER/TPA	
INSURER CLAIM NUMBER	

Date of most recent examination by this office: 11-8-07 (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 11-8-07 (date) to (date)

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

NAME (Type or Print)

SIGNATURE DEGREE: MD

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

CITY

STATE LICENSE #/REGISTRATION #

AREA CODE TELEPHONE # DATE SIGNED 11-8-07

MN RWO1 (7/01)

md