

ESSG

Suzlon Accident Report

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

Team Member: Travis Comer

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: TJewora

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

Failure of PPR, PASTA GOT ON ARM'S

Witnesses names

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

Employee Feedback

Travis Comer
Team Member Signature

28/Dec 07
Date

Brenda Z...
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.

ESSG

Referral for Medical Treatment Report to Employer

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 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: Demetritis _____ 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 U8521865

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



STEP 1 To be completed by COLLECTOR / DONOR

Donor I.D. 520843490
Donor Name (last, first) or SSN COMERT TRAVIS
Donor Daytime Phone 6515871605
Social Security No, Employee No. or other Identification No.
Specimen Type: Blood Urine Oral Fluid
Referring Phys. / Company Suzlon

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 12-28-2007

MRO:

Account # 93470

Test(s) Ordered 88543



STEP 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

STEP 3 To be Completed by COLLECTOR

Specimen temperature must be read within 4 minutes of collection. Specimen Temperature within range: (90°-100°F/32°-38°C) YES No, Remark Required 81605

STEP 4 To be Completed by COLLECTOR

Collection Site Location: Facility and Address 4B1
PIPESTONE COUNTY MED CENTER
PIPESTONE, MN 56164

Collection Site Phone No. (507) 8255811 Fax No. (507) 8256081

Date and Time of Collection: 12-28-2007 17:00 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.

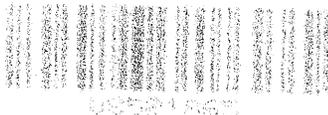
X [Signature] Debra H. Grootwassink
Signature of Collector
(PRINT) Collector's Name (First, MI, Last)

SPECIMEN BOTTLE(S) RELEASED TO:

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

STEP 5

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