What we do …

SAFETY MANAGEMENT:

Among its other benefits, maintaining a safe workplace is simply good business. It results in reduced insurance rates and more productive workers. Pinnacle PEO Corporation implements and oversees a comprehensive customized safety program for each client. Included are safety manuals and employee education programs. Safety management services include:

- Preparation and implementation of safety policies practice manual
- Development of safety programs and inspection procedures established and conducted by our company's safety specialists
- Coordination of safety education
- Ongoing safety audits OSHA/HAZCOM reporting and compliance

WORKER'S COMPENSATION:

Pinnacle PEO provides extensive services for workers with job-related injuries. Worker's Compensation services include:

- Provision of affordable worker's compensation coverage
- Administration of claims for wages compensation and management assistance to injured workers
- Administration of rehabilitation and return-to-work, light-duty programs
- Filings and follow-up of all required injury reports

Policies and Procedures

INITIAL REPORTING:

Any and every job related injury must be to Pinnacle Peo Corporation the same day of the occurrence. Please report the injury, even if you are uncertain if the injury is work related.

Benefits of Immediate Reporting:

- Authorization of medical care
- Expediting benefits to the injured
- Meeting state and company requirements
- Avoiding late penalties
- Investigation of the loss
- Decreased costs of claims

It has been proven that late reporting increases the cost of a claim. Therefore, working together, we may be able to keep down the costs of premiums.

HOW TO REPORT:

You should contact Eva Gomez at 210.344.2088 **as soon as possible** following an injury. She will fax over a first report of injury form to be completed and faxed back to the office Attn: Worker's Compensation Dept. at 210.344.2777. Each client should keep a copy of each form in their personnel files and then mail the originals to:

PINNACLE PEO CORPORATION
Attn: Worker's Compensation Dept.
9311 San Pedro, Suite 700
San Antonio, Tx. 78216

LATE REPORTING:

State worker's compensation laws require that injuries be turned in to the carrier within 3-7 days, depending on the state. Failure to do so will result in fines, interest and penalties being assessed. **Your Company will then be responsible for the payment of said protocol was not followed.**

PHYSICAN REPORT:

Physician reports should be requested via phone or fax from the Worker's Compensation Department at Pinnacle **before** the injured employee goes to a provider. At the time, Pinnacle will provide the client with the name(s) of an approved medical provider if required by the state. The supervisor /foreman of said injured employee should complete and sign the top portion of the physician report and distribute it to the employee

The injured employee then takes the form with them to the approved provider's office. The attending physician should complete and sign the bottom portion of the form and the employee should return it to the supervision/foreman.

You, the client, should keep a copy of the report for personnel files. You should then fax the report and mail the original to Pinnacle PEO.

RETURNING TO WORK:

A return to work status form must be completed as soon as an employee has returned to work. This form may also be requested via phone or fax.

The client should complete the form and make a copy of it, along with the physician's release to keep in the personnel file. You should then fax both forms and mail the originals to Pinnacle PEO.

CERTIFICATES OF INSURANCE:

If your contractor(s) requires that you provide them with a worker's compensation certificate, please fax us a certificate request form. We will then fax a copy to the contractor(s), followed by a mailed original.

To ensure proper delivery, please include the correct mailing address and fax number for each contractor. If this procedure is followed, we will have ample time to send the certificates out, thus eliminating any delay.

In addition, if you, the client, deal with sub-contractors, then Pinnacle will need a worker's compensation certificate of insurance from each of them. All request and/or sub-contractor should be faxed Attn: Worker's Compensation Dept. to 210.344.2777 client copies of certificate will be sent with payroll.

PROCEDURES FOR CERTIFICATE REQUESTS

Request will not be taken over the phone, they must be faxed or e-mailed to the attention of the Worker's Compensation Dept.
Fax #: 210-344-5855 e-mail: egomez@pinnaclepeo.com

Request forms must be filled in completely.

Certificates requests will not be processed without complete mailing address for the Certificate holder.

Certificates will not be issued until the Client company has turned in their first payroll.

If you require a Waiver/or Alternate Employer endorsement the second form must be filled out completely.

PINNACLE PEO CORPORATION A Professional Employer Organization

Worker's Compensation Certificate Request

To: Pinnacle PEO Corporation **Date:_____**
Telephone # (210) 344-2088

CLIENT NAME: _____AFFILIATE: _____

CLIENT ADDRESS: _____

CITY, STATE, ZIP: _____

CLIENT FAX: _____

CERT HOLDER'S NAME: _____

ATTN: _____

ADDRESS _____

CITY, STATE, ZIP: _____

CERT HOLDER FAX: _____

TRANSMIT CERTIFICATE TO CLIENT AND HOLDER: VIA FAX___ or MAIL___

JOB & WORKSITE: _____

_____

DOES THE CERTIFICATE HOLDER NEED A WAIVER OF SUBROGATION? _____

IF YES, FILL OUT SECOND PAGE.

DOES THE CERTIFICATE HOLDER NEED AN ALTERNATE EMPLOYER

ENDORSEMENT? _____ IF YES, FILL OUT SECOND PAGE.

PINNACLE PEO CORPORATION A Professional Employer Organization

9311 San Pedro Ste 700 **Phone #: 210-344-2088**
San Antonio, TX 78216 **Fax #: 210-344-5855**

WAIVER OF SUBROGATION / ALTERNATE EMPLOYER REQUEST:

To: Worker's Compensation Dept **FAX # (210) 344-5855**

EMAIL ADDRESS: **egomez@pinnaclepeo.com**

CLIENT:

CERTIFICATE HOLDER:

PROJECT:

DURATION OF PROJECT:

PROJECTED START DATE:

LOCATION OF PROJECT:

DETAILED SCOPE OF WORK:

ESTIMATED MAN HOURS:

TOTAL EMPLOYEE ON THE JOB:

OWNER OF EQUIPMENT TO BE USED ON PROJECT:

PLEASE READ AND THEN INTIAL AFTER THE APPROPRIATE PARAGRAPH (REQUESTS WILL NOT BE PROCESSED UNLESS YOU HAVE INITIALED THAT YOU HAVE READ AND UNDERSTAND WHAT IS INVOLVED:

Waiver of Subrogation Endorsements: If a waiver of subrogation endorsement is issued in favor of a certificate holder for one of our clients, this prevents us from recovering against that certificate holder in case of negligence on their part. In other words, if one of our employees is injured due to negligence on the part of the certificate holder, we have waived our rights to obtain monies from them. This is why we should try to avoid issuing this endorsement._____

Alternate Employer Endorsements: This endorsement extends coverage to the client for any liability it may have for injuries to leased employees under Workers' Compensation coverage. There shouldn't be a problem providing this endorsement as long as it is in the favor of the client and not the certificate holder since we don't normally subrogate against our clients._____

ACCIDENT INVESTIGATION FORM

• Accident investigation assists you in reducing or preventing future occupational injuries and illnesses.

• This form requests all the information that DWC says you must record for each on-the-job injury, fatality, and occupational disease. Employers must keep injury records for five years after the last day of the year in which the injury occurred.

This is an ☐ Injury ☐ Disease ☐ Fatality ☐ Near-miss

TODAY'S DATE _____

DATE REPORTED _____

COMPANY _____

DEPARTMENT _____

SUPERVISOR _____

PHONE NO. _____

1. Name of Person Involved 2. Sex		3. Social Security Number	4. DOB 5. Date of Incident
6. Home Address _____ _____ Phone ( ) _____	7. Time and day of Incident _____ a.m; _____ p.m; day of week _____		8. Specific Location of Incident Was it on employer's premises? Yes / No
	9. Employee's Occupation		10. Job Task at Time of Incident
13. Name and Address of Treating Physician _____ _____ Phone ( ) _____	11. Length of Service _____Years; _____ Months		12. Employee was Working ☐ Alone ☐ With Fellow Workers ☐ Other
	14. Employment category ☐ Regular, full-time ☐ Temporary ☐ Regular, part-time ☐ Non-employee ☐ Seasonal		15. Experience in Occupation at Time of Incident ☐ Less than 1 month ☐ 1 to 5 months ☐ 6 months to 1 year ☐ 1 to less than 5 years ☐ 5 or more years
16. Name and Address of Hospital _____ _____ Phone ( ) _____	17. Phase of Employee's Workday at Time of Injury ☐ During break period ☐ During meal period ☐ Working overtime ☐ Entering or leaving the building ☐ Performing work duties ☐ Other(explain below)		
	18. Name of employee's immediate Supervisor at the time of incident? Witnessed ☐ Yes ☐ No		
19. Employee's Wage (pay per Hour)	Other Witnesses		
21. Voluntary benefits paid by the employer, if any	_____		

22. PART of BODY INFURIED or AFFECTED

☐ Skull, Scalp ☐ Jaw ☐ Abdomen ☐ Shoulder ☐ Wrist ☐ Knee ☐ Foot
☐ Eye ☐ Neck ☐ Back ☐ Upper Arm ☐ Hand ☐ Thigh ☐ Toe
☐ Nose ☐ Spine ☐ Pelvis ☐ Elbow ☐ Finger ☐ Lower Leg ☐ Ankle
☐ Mouth ☐ Chest ☐ Other Body Part ☐ Forearm ☐ Hip ☐ Other _____

23. NATURE of INJURY or ILLINESS

☐ Puncture ☐ Bruise, Contusion ☐ Skin Disorder ☐ Amputation ☐ Muscle Sprain ☐ Cumulative Truman Dis.
☐ Laceration ☐ Dislocation ☐ Burn ☐ Insect/Animal Bite ☐ Muscle Strain ☐ Irritation
☐ Fracture ☐ Abrasion ☐ Respiratory ☐ Foreign Body ☐ Hernia ☐ Infection
☐ Heat/Cold Stress ☐ Hearing loss ☐ Chemical Exp. ☐ Other _____

24. DISPOSITION

☐ Days away from work # _____
☐ Restricted work days # _____
☐ Date returned to work # _____
Sent to: ☐ Doctor ☐ Hospital

25. DIAGNOSIS

_____
_____
_____

26. SEVERITY

☐ First Aid ☐ Medical Treatment
☐ Lost Work Days ☐ Fatality
Other: Specify _____
_____

27. WHAT CONDITION of TOOLS, EQUIPMENT, or WORK AREA CONTRIBUTED TO INCIDENT? ■ **Not Applicable**

☐ Close Clearance/ Congestion ☐ Floors/Work Surfaces ☐ Inadequate Housekeeping ☐ Defective Tools/Equip./Veh.
☐ Hazardous Placement ☐ Inadequate Ventilation ☐ Equipment Failure ☐ Illumination
☐ Inadequate Warning System ☐ Equipment/Workstation Design ☐ Inadequate Guards/Barrier ☐ Inadequate/Improper P.P.E.

28. WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS? ■ **No Substandard Conditions**

☐ Abuse or Misuse ☐ Inadequate Supervision ☐ Inadequate Purchasing ☐ Inadequate Engineering
☐ Inadequate Maintenance ☐ Inadequate Tools/Equip. Mat. ☐ Improper Work Surfaces ☐ Wear and Tear
☐ Lack of Knowledge/Training ☐ Improper Motivation ☐ Inadequate Capacity ☐ Lack of Skill

29. WHAT ACTION or INACTION CONTRIBUTED to the INCIDENT? ■ **No Applicable**

☐ Failure to Make Secure ☐ Under Influence Drugs/Alcohol ☐ Failure to Warn/Signal ☐ Inadequate/Improper P.P.E. Use
☐ Nullified Safety/Control Devices ☐ Used Defective Equipment ☐ Horseplay/Distractive Active ☐ Operating at Improper Speed
☐ Used Equipment Improperly ☐ Improper Lifting ☐ Operating Procedure Deviation ☐ Used Wrong Tool/Equipment
☐ Running/Rushing/Acting in Haste ☐ Improper Loading ☐ Unauthorized Actions
☐ Improper Technique ☐ Improper position ☐ Servicing/Operating Equipment
☐ Other _____

30. PROBABLE RECURRENCE

☐ Frequent ☐ Occasional ☐ Rare

31. LOSS SEVERITY POTENTIAL

☐ Major ☐ Serious ☐ Minor

32. PERVENTIVE MEASURES: (What corrective actions have been taken or are planned to prevent a recurrence?)

☐ Improve Enforcement ☐ Improve Clean-up Procedures ☐ Repair/Replace Equipment ☐ Corrective Counseling
☐ Improve Storage/Arrangement ☐ Rotation of Employee ☐ Eliminate Congestion ☐ Improve/Change Work Method
☐ Identify/Improve P.P.E. ☐ Install/Revise Guards/Devices ☐ Task Analysis to be Completed
☐ Task Analysis/Procedure Revision ☐ Improve Design/Construction ☐ Job Reassignment of Employees
☐ Use Other Materials/Supplies ☐ Improve Illumination ☐ Mandatory Pre-Job Instructions
☐ Improve Ventilation ☐ Reinstruction of Employees ☐ Other _____

33. EMPLOYEE'S DESCRIPTION of INCIDENT (Attach sheet for additional comments) ■ **Comments Sheets**

_____
_____

34. SUPERVISOR'S DESCRIPTION of INCIDENT (Attach sheet for additional comments) ■ **Comments Sheets**

_____
_____

35. SPECIFIC CORRECTIVE ACTIONS or PREVENT MEASURES TAKEN

Corrective Action Taken	Person Responsible	Target Date	Date Completed
_____	_____	_____	_____
_____	_____	_____	_____

Supervisor's Signature _____ Date _____