

Supervisor's Injury Investigation Report



PINNACLE
EMPLOYEE LEASING

*Important- Please complete form **IN FULL** and fax within **24 HOURS** of injury to 941-833-2075.*

Employer/Client Information

Company Name: _____	Company Contact: _____
Company Phone Number: _____	Division: _____

Employee/Injured Party Information

Employee Name: _____	DOB: _____
Social Security #: _____	Daytime Phone: _____

Accident Information

Date of Accident: _____	Time of Accident: _____ AM/PM
Last Date Worked: _____	Paid in Full for Date of Accident: Yes/No
Place of Accident: _____	
Describe the work being done at the time of accident and how the accident occurred: _____	
Does the employer agree with the description of accident: Yes/No. If No, please explain: _____	
What action has been taken to prevent a similar injury (if applicable): _____	
Witnesses (please list names): _____	

Injury/Illness Information

Type of Injury (please be specific): _____
Area of Injury (please be specific, i.e. right, left, etc.): _____

Please list any pre-existing conditions that may apply: _____

Treatment Facility Information

Name of Facility: _____	Phone # of Facility: _____
Address of Facility: _____	
Was Drug Screening Administered: Yes/No. If No, please state reason _____	

Did Employee Refuse Treatment: Yes/No. If Yes, please sign Statement of Release	
Was the visit authorized by Employer: Yes/No	
Will you continue to pay wages in lieu of W/C: Yes/No	

Supervisor's Signature: _____	Date: _____
Employee's Signature: _____	Date: _____

115 W. Olympia Avenue Suite 121, Punta Gorda, Florida 33950
Phone: 941-833-2065 Fax: 941-833-2075 Website: www.pinnacleel.com

Statement of Release Form



Important- Please complete form IN FULL and fax within 24 HOURS of injury, along with Supervisor's Accident Investigation Report, to 941-833-2075.

I understand that it is my right to refuse treatment. Therefore, I choose not to seek medical treatment at this time.

I understand that since I have suffered an on-the-job injury or illness, I must take a Post-Accident Drug Screening due to the Post-Accident/Reasonable Suspicion Program. I understand that refusal of these procedures can lead to disciplinary action and/or termination of my employment.

Injured Employee's Signature

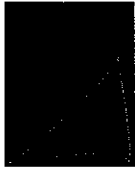
Date

Supervisor's Signature

Date

**115 W. Olympia Avenue Suite 121, Punta Gorda, Florida 33950
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Initial Treatment/Drug Screen Authorization



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Please complete and send with employee to treating facility.

Employee/Injured Party Information

Name: _____
Social Security Number: _____

Accident Information

Date of Accident: _____
Brief Description of Accident: _____

Injury Information

Type of Injury/Illness Sustained: _____

Provider:

Please accept this as our request to treat and/or drug screen the injured party listed above. Please take notice that since our company has a Post Accident/Reasonable Suspicion Program, we require that all injured parties, seeking medical treatment, receive a Post-Accident drug screen. If for any reason this cannot be administered, please contact us at the number listed below.

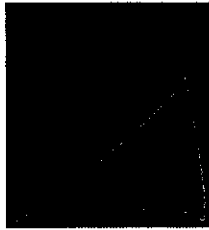
Please send all invoices for medical Treatment to:
*USIS
P.O. Box 616648
Orlando, Florida 32861-6648
Phone: 800-444-9098
Fax: 407-352-5788*

Please send all invoices for drug screening to:
*Total Compliance Network
5440 NW 33rd Avenue Ste 106
Ft. Lauderdale, Florida
Phone: 954-677-1200
Fax: 954-677-1201*

If you have any questions, or need further information, please contact, Jesse Corbett with Pinnacle Employee Leasing, at 941-833-2065.

Authorization given by (please print): _____
Signature: _____
Title: _____
Date: _____

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Post-Accident/Reasonable Suspicion Program

PEL has recognized that drug and alcohol abuse is an on the job problem as well as a social problem. We believe that abuse of alcohol and the use of illegal drugs endangers the health and safety of the abusers and of others around them. PEL has committed to creating and maintaining a Post-Accident/Reasonable Suspicion Program without jeopardizing the job security of valued, but troubled, leased employees, provided they are prepared to help us help them. Our Post-Accident/Reasonable Suspicion Program now formally states that it is a condition of acceptance as a leased employee by PEL to refrain from reporting to work or working with the presence of drugs/alcohol in hers/his body. This prohibition includes the possession, use, or sale of illegal drugs and the abuse of alcohol.

To ensure PEL is in compliance with their Post-Accident/Reasonable Suspicion Policy, a program of Drug Testing will begin on June 30, 2005. Let it be clearly understood it is a condition of acceptance as a leased employee by PEL that individuals avoid the use, possession, sale, or any association at all with illegal drugs and/or the abuse of alcohol. Leased employees found on the job to be under the influence of illegal drugs or alcohol, or who violate this policy in other ways, may be terminated.

Please understand, as a condition of your continued employment, where Reasonable Suspicion of drug and/or alcohol use exists, that PEL will require you to undergo substance abuse screening by urinalysis for drugs and blood for alcohol. In the event of an on-the-job injury, PEL will require you to undergo Post-Accident substance abuse screening, by urinalysis, for drugs and when necessary, blood for alcohol.

Refusal of these procedures can lead to disciplinary action and/or termination of employment.

It is important that we all work together to deal with substance abuse so our work environment is a safer, more rewarding place to work.

Thank you for your cooperation!

Pinnacle Employee Leasing

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