Form DWC102
(Accident Prevention Plan Cover Sheet)

The **Approved Professional Source Safety Consultant** and the identified employer **(Rejected Risk Requiring Accident Prevention Services)** will complete the **Accident Prevention Plan Cover Sheet** [Form DWC102]. This form will serve as a cover sheet to the plan developed in accordance with the Program Review Report (DWC101).

The original signed form should be maintained by the employer and a copy sent to the Texas Department of Insurance, Division of Workers' Compensation (DWC) along with a copy of the accident prevention plan.

Send DWC's copy to the attention: **Workplace Safety, MS-26, Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Dr, Ste. 100, Austin, Texas 78744.**

[Art. 5.76-3, Section 8, Texas Insurance Code, DWC Rules Chapter 165]

INSTRUCTIONS FOR COMPLETING THE ACCIDENT PREVENTION PLAN COVER SHEET

Part I. Employer's Information

1. **Business Name** - Name of company that has been identified as Rejected Risk Requiring Accident Prevention Services.
2. **Employer's Contact Name -** Individual who will be the primary contact for answering questions and accompanying the inspector during the follow-up inspection.
3. **Business Address** - Mailing Address.
4. **Physical Address for Texas Location -** Street address or physical location information for primary Texas work site. **(NO P. O. BOX)**
5. **Employer's City, State, Zip Code.**
6. **Employer's Contact, City, State, Zip, if different from Business.**
7. **Federal Tax I.D. Number -** Enter the Federal Tax I.D. Number assigned (FEIN).
8. **North American Industry Classification System (NAICS) Code -** Obtain from the insurance policy. Verify with the employer's records.
9. **Telephone Number, Fax Number, and E-mail Address -** Best contact phone, fax number, and e-mail address for client.

Part II. Consultant's Information:

1. **Consultant's Name.**
2. **Consultant's Telephone Number.**
3. **Consultant's Mailing Address.**
4. **DWC# -** Approved Professional Source Consultant's Number assigned by DWC or previously assigned by Texas Workers' Compensation Commission.
5. **Consultant's City, State, Zip.**

Part III. Summary of Employer Operations:

Include a brief description of the business. Include the type of service performed or product(s) manufactured, the number and location of all facilities, the number of employees, number of shifts, and any other information that will provide a brief overview of the operation. If additional space is required, add additional sheets of paper with the appropriate information and attach.

Part IV. Signature/Statement:

1. **Consultant's signature and date.**
2. **Employer's signature and date.**
3. **Employer's statement.**

The consultant's signature indicates that he/she personally inspected the above identified employer and in his/her professional opinion the Accident Prevention Plan meets the requirement of the law and division rules. The employer's signature indicates agreement with the plan, unless noted. If the "disagree" block is checked, the employer must submit a written explanation of the disagreement along with the Accident Prevention Plan.

Consultation Cost: indicate the estimated or actual cost to the employer of the Program Review and of developing the Accident Prevention Plan.

Texas Department of Insurance

Division of Workers' Compensation
Workplace Safety, MS-26
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609
512-804-4000 • 512-804-4001 fax • www.tdi.state.tx.us

ACCIDENT PREVENTION PLAN COVER SHEET

(THE ACCIDENT PREVENTION PLAN MUST ACCOMPANY THIS COMPLETED COVER SHEET)
For Rejected Risk Employer Use

Part I EMPLOYER'S INFORMATION

CORPORATE INFORMATION		TEXAS INFORMATION
1. Employer Name:		2. Texas Business Name
3. Business Mailing Address		4. Physical Address for Texas Location:
5. City State ZIP		6. City State ZIP
7. Federal Tax I.D. Number (FEIN)	8. NAICS	9. Texas Telephone Number: ( ) Fax Number: ( ) E-mail Address:

Part II CONSULTANT'S INFORMATION

1. Name	2. Telephone Number: ( )
3. Address	4. DWC Number ____________________
5. City State ZIP	

Part III SUMMARY OF EMPLOYER OPERATIONS (See Instructions)

BRIEF DESCRIPTION OF FACILITIES & PRODUCT OR SERVICE PROVIDED BY EMPLOYER:

NUMBER OF SHIFTS:
NUMBER OF EMPLOYEES:
NUMBER OF LOCATION(S) IN TEXAS: *NUMBER OF LOCATION(S) ON THE PROGRAM REVIEW:*

Part IV SIGNATURE/STATEMENT The consultant's signature indicates that he/she personally inspected and evaluated the above identified employer and in his/her professional opinion the Accident Prevention Plan meets the requirements of the law and Texas Department of Insurance, Division of Workers' Compensation Rules. The employer's signature indicates agreement with the plan unless noted otherwise in item number 3.

1. Consultant's Signature ____________________________ Date__________
2. Employer's Signature ____________________ Title________________ Date
3. Employer's Statement ☐ Agree ☐ Disagree (Attach explanation of disagreement) Consultation Cost: