

SUPPLEMENTAL WORKERS' COMPENSATION APPLICATION

APPLICANT NAME: _____

Type of Company: For Profit Not for Profit **Is this Facility:** Union or Non-Union

Date Company was established: _____ **# Years under current ownership** _____

Is Applicant a current member of a National or State Trade Association? Yes No

If Yes, please indicate Association _____

Business Operations (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Ambulance Services | <input type="checkbox"/> Assisted Living Center | <input type="checkbox"/> Community Organization |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Healthcare Staffing Agency | <input type="checkbox"/> Home Care Services |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Medical Equipment Provider | <input type="checkbox"/> Medical Services |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Nursing Home/Long Term Care | <input type="checkbox"/> Physical Therapy/Occupational Health |
| <input type="checkbox"/> Rehab Clinic /Drug or Alcohol | <input type="checkbox"/> Retirement Home | <input type="checkbox"/> Social Service Organization |
| <input type="checkbox"/> School for Challenged | <input type="checkbox"/> Substance Abuse Counseling | <input type="checkbox"/> Women's Shelter |
| <input type="checkbox"/> Visiting Nurse Services | <input type="checkbox"/> Other: _____ | |

Employees: # Full Time ____ # Part Time ____ Turnover rate: ____ % **Total # of beds (if applicable):** ____

Are employees provided with: Health Insurance Yes No Paid Vacation & Sick Time: Yes No

Are subcontractors utilized? Yes No **If Yes, what services do they provide?** _____

If Yes, are Certificates of Insurance obtained annually and kept on file? Yes No

Does Applicant use leased or temporary employees from other companies? Yes No

Does Applicant provide leased or temporary employees to other companies? Yes No

List any locations, including construction code, with 100 or more employees. List how many at each location _____

Do any employees drive personal and/or company vehicles to and from clients during the workday? If yes, please complete the Fleet Questionnaire attached.

Please indicate below which of the following Safety Programs and Best Practices are currently operational:

- | | | |
|---|---|--|
| <input type="checkbox"/> Driver Safety Program | <input type="checkbox"/> Accident/Incident Investigation | <input type="checkbox"/> Labor/Mgmt Safety Committee |
| <input type="checkbox"/> Safety Incentive Program | <input type="checkbox"/> Patient Handling/Transfer Training | <input type="checkbox"/> Mentoring for new employees |
| <input type="checkbox"/> New Employee Orientation | <input type="checkbox"/> Personnel Evaluations include safety | <input type="checkbox"/> Driver Training / Travel logs |
| <input type="checkbox"/> Return to Work/Modified Duty | <input type="checkbox"/> Screening process for new hires | <input type="checkbox"/> Functional testing of new hires |
| <input type="checkbox"/> Written Safety Program | <input type="checkbox"/> Documented Facility inspections | <input type="checkbox"/> Competency-based training |

Does the hiring process include:

- | | | |
|--|---|--|
| <input type="checkbox"/> Post Offer Job Function Testing | <input type="checkbox"/> Criminal Background Check | <input type="checkbox"/> Motor Vehicle Record Check |
| <input type="checkbox"/> Pre-Placement Drug Testing | <input type="checkbox"/> Post Offer Medical Examination | <input type="checkbox"/> Drug-free Workplace |
| | <input type="checkbox"/> Job Descriptions | <input type="checkbox"/> Pre-Placement Reference Check |

Please indicate below which of the following are currently operational in your organization:

- Management's commitment to Safety.
- Return-to-Work is offered to all injured workers cleared for light duty
- Restrictions are placed on the type of footwear allowed
- Employees are provided with slip resistant products for their shoes during the winter months
- Applicant provides group transportation to employees

Lifting Program - Which of the following best describes the patient handling program?

- No manual lifting allowed: All lifting done with mechanical devices.
- Minimal manual lifting : Most lifting done with mechanical devices. Situations requiring manual lift utilize 2+ staff, lifts, gait belts, slide sheets, etc.
- No Formal lifting program in effect.
- Not applicable – no patient handling performed by this applicant

Please provide the following:

1) Informational brochures describing operations, locations, services, etc,

2) Loss history for the current and the 3 prior complete policy years along with the loss runs.

3) Applicant's website address: _____

Applicant Name (please print)

(Ed. 02.2011)

Signature

Title