



# MEDICAL SERVICES SUPPLEMENTAL APPLICATION

- 1. Name of Organization: \_\_\_\_\_
- 2. Address: \_\_\_\_\_  
If there is more than one location, please attached a list of the locations.
- 3. Phone: \_\_\_\_\_ FEIN #: \_\_\_\_\_
- 4. Broker Name: \_\_\_\_\_ Broker Agency: \_\_\_\_\_
- 5. Class Code \_\_\_\_\_ Payroll (\$75k Max per employee) \_\_\_\_\_  
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- 6. Number of Full-Time employees: \_\_\_\_\_ Number of Part-Time employees \_\_\_\_\_  
If at least 25 total employees, do you have a safety committee?  Yes  No
- 7. Do you have an experience mod?  Yes  No  
Please attach copy of worksheet
- 8. Do you have a Bloodborne Pathogens program?  Yes  No
- 9. Do you have a Hazard Communication program?  Yes  No
- 10. Do you provide Personal Protective Equipment?  Yes  No
- 11. Do you have a Workplace Violence Prevention program?  Yes  No
- 12. Do you accommodate Restricted Duty?  Yes  No

*Attach currently valued loss runs (5 years including current)*

\_\_\_\_\_  
Applicant Name Title

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Phone:

\_\_\_\_\_  
Signature Date