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):

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

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 _____

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

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

Does the hiring process include:

- ☐ Post Offer Job Function Testing
- ☐ Pre-Placement Drug Testing
- ☐ Criminal Background Check
- ☐ Post Offer Medical Examination
- ☐ Job Descriptions
- ☐ Motor Vehicle Record Check
- ☐ Drug-free Workplace
- ☐ 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 5 prior complete policy years along with the loss runs.

3) Applicant's website address: _____

_____	_____	_____	_____
Applicant Name (please print)	**Title**	**Signature**	**Date**

(Ed. 01.2015)

AUTO FLEET SUPPLEMENTAL APPLICATION

This form needs to be completed for any organization with 5 or more employees as drivers of company vehicles.

General Information:

1. Name of organization: _____
2. What is your radius of operations? _____
3. Do you travel outside the state? □ Yes □ No
   If yes, where _____ Why _____
4. What are your hours of operation?: _____AM to _____PM

Driver Information:

5. Do you have a drug testing policy in place: □ Yes □ No □ Upon Hire □ For Cause □ Annually
6. MVR's obtained? □ Yes □ No □ Upon Hire □ For Cause □ Annually
7. Do you have an MVR's criteria in place? □ Yes □ No
8. Do any of your employees take a company vehicle home? □ Yes □ No If yes, how many _____
9. Do you provide driver training? □ Yes □ No □ Upon Hire □ For Cause □ Remedial
   Type of Training _____
10. Do you require a minimum number of years driving experience? □ Yes □ No If yes, how many years _____
11. Please indicate the total number of drivers who drive agency vehicles:
    _____Full Time _____ Part Time _____ Volunteer _____Other
12. How many drivers have a special license?
    _____ P = Passenger
    _____ S = School Bus (Student Transportation Vehicles, Activity Vehicles, Taxi) Livery, Service Bus, and Motor Coach)
    _____ V = Student Transportation Vehicles (Activity Vehicles, Taxi, Livery, Service Bus and Motor Coach)
    _____ A = Activity Vehicles (Taxi, Livery, Service Bus, and Motor Coach)
    _____ F = Taxi, Livery, Service Bus, Motor Coach
13. Do employees use their own personal vehicles for company business? □ Yes □ No
    Do you obtain proof of insurance for drivers using their personal autos? □ Yes □ No
    How many employees drive their personal vehicles for the business:? _____
    What auto liability limits do you require the employee to have on their personal auto policy? _____
    MVRs obtained? □ Yes □ No □ Upon Hire □ For Cause □ Annually

Vehicle Information:

14. Number of: _____Agency Vehicles _____ Personal Vehicles use by Employees
15. Number of Agency vehicles by type:
    _____ Passenger Vehicles _____ Wheelchair Transport Vehicles
    _____ Pick- Ups _____ 15 Passenger Vehicles
    _____ Mini Vans _____ Others (please list)
16. What safety equipment do the vehicles have?
    _____ GPS _____ Inside Vehicle Camera _____ Outside Vehicle Camera _____ Other
17. Average number of employees in a vehicle at any 1 time: _____ # of daily trips per vehicle _____
18. Is there a written fleet safety program? □ Yes □ No If yes, attach Table of Contents
19. What Fleet Safety Program do you have in place?
    _____ Accident Investigation _____ Roadside Emergency Kit _____New Hire Orientation
    _____ Wheelchair Tie Down Training _____Pre & Post Trip Inspection _____Other
20. Maintenance Program:
    Describe inhouse vehicle maintenance program: _____
    _____
    Describe outsourced vehicle maintenance program: _____
    _____

_____ _____ _____

Applicant Name Signature Date