



Healthcare Industry Questionnaire for Temporary Staffing Agency

Legal Name of Temporary Staffing Agency:	Application ID or Policy Number:
Trade Names of Temporary Staffing Agency:	

GENERAL INFORMATION – Include details in Comments section for all YES responses.

1. Are there any commonly owned businesses? Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:
2. Are these businesses insured? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Do you have operations in other states? Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Do you have any foreign travel exposures? (If yes, provide details concerning countries, duration and number of employees): Yes <input type="checkbox"/> No <input type="checkbox"/>	

PERSONNEL PRACTICES

Do you implement the following for all employees including the temporary employees provided to clients? If yes, provide details:

1. Pre-employment physicals	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Pre-placement drug screening	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Periodic drug testing	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Criminal background checks	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Motor vehicle checks on drivers	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Job experience & certification requirements	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. Minimum experience requirements	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. New-hire orientation program	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Employee handbook	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Performance appraisals	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Wellness program in place	Yes <input type="checkbox"/> No <input type="checkbox"/>	

EMPLOYEE BENEFITS – If yes, provide details:

Do you offer the following benefits to your direct employees?		% of Employer Contribution	% of Employees enrolled	Details
1. Medical	Yes <input type="checkbox"/> No <input type="checkbox"/>			
2. Dental	Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>			
4. Retirement	Yes <input type="checkbox"/> No <input type="checkbox"/>			
5. Paid vacation days	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details		
6. Paid sick days	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details		
Do you offer the following benefits to the employees you send to clients?		% of Employer Contribution	% of Employees enrolled	Details
7. Medical	Yes <input type="checkbox"/> No <input type="checkbox"/>			
8. Dental	Yes <input type="checkbox"/> No <input type="checkbox"/>			
9. Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>			
10. Retirement	Yes <input type="checkbox"/> No <input type="checkbox"/>			
11. Paid vacation days	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details		
12. Paid sick days	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details		

CLIENT INFORMATION:

Average number of new clients added each year

Average number of new employees each year

Client Exposure Breakdown

	# of Clients	# of Employees		# of Clients	# of Employees
Ambulance Services			Hospitals – All Employees		
Alcoholic and Drug Recovery			Institutional Employees		
Biomedical Research Laboratories			Nursing Homes		
Congregate Living Facilities - Elderly			Physicians		
Day Care Centers - Child			Residential Care Facilities - Adults		
Dentists and Dental Surgeons			Residential Care Facilities - Children		
Home Care Services			Residential Care Facilities – Developmentally Disabled		
Home Infusion Therapists			Shelter Workshops		

Total # of Full-Time Office Staff: Total # of Temporary Employees:
 Number of W2's: Number of 1099's:

Do you require Independent Contractors to carry their own WC coverage? Yes No

If no, explain reason:

CLIENT SCREENING – If yes, provide details.

1. Do you have established criteria for new client selection?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Do you complete job hazard assessments for all new clients or new tasks?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Do you have procedures in place to eliminate clients for poor safety practices or loss experience?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Do you review client's new worker orientation procedure?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. Do you review client's response procedures for emergency or accidents?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. Do you inspect worksite for safety "prior" to employee placement as well as on-going unannounced inspections?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Do you or the client provide employees with description of the job assignment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Do you or the client provide safety training?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. What percentage of your client's patients are unable to "assist in the lift" during patient handling tasks?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

SAFETY PRACTICES/PROGRAMS – If yes, provide details.

1. Do you have a full-time safety director? (If yes, provide name and title.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Do you perform accident investigations?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Are your supervisors held accountable for safety at client worksites?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Do you or your client provide employees with PPE?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

SAFETY PRACTICES/PROGRAMS – If yes, provide details (Continued).

5. Do you conduct employee safety meetings?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. Do you offer an employee safety incentive program?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Do you offer modified duty/early return to work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Do you have an Ergonomics Program? (If yes, describe what prompted the program, e.g. compliance, proactivity, etc. If no, are there two or more repetitive motion injuries in the past 12 months from similar jobs?)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Do you or your client enforce the use of lifting equipment practices?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
10. What is the frequency of Ergonomics or Back Safety Training?		Date of last training: <input type="text"/>
11. Do you or your client have a written Safe Patient Handling Plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
12. Do you or your client have a Workplace Violence Prevention Plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
13. Do you have a Heat Illness Prevention Program?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. Do you have a Respiratory Protection Program?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
15. Do you have a Driver Safety Training Plan or Fleet Safety Program?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
16. Do you have a Facility Emergency Evacuation Plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
17. Do you have written Lockout/Tag Out/Block Out procedures?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
18. Do you have a Hearing Protection Program/Annual Audiogram?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
19. Do you have an Aerosol Transmissible Disease (ATD) exposure control plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
20. Do you have ATD screening procedures?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. Do you have a Chemical Hygiene Plan for lab chemicals, wastes, disinfectants?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. Do you have a Sharps Policy forbidding recapping and/or re-sheathing needles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
23. Do you offer pre- or post-exposure viral and bacterial vaccinations?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
24. Do you have an Exposure Control Plan for blood borne pathogens?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
25. Do you have an Enforcement of Universal Precautionary Policy for blood and infectious materials?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
26. Do you treat for communicable diseases (i.e., COVID-19, HIV, AIDS, etc.)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
27. How do you maintain contact with your employees?		

CLAIMS MANAGEMENT & REPORTING - If yes, provide details if applicable.

1. Do you have a full time claims manager? (If yes, provide name and title.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Do you have claims fraud investigation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Do you have established injury reporting procedures?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Do you require all WC claims to be reported within 24 hours?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. Is there a set procedure for reporting claims which also includes a formal written accident investigation report?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. Do you conduct drug testing after an injury occurs? (If yes, provide details on procedure.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Do you have a process to identify claims frequency and claims trends? (If yes, provide details.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Do you conduct mid-term monitoring and reporting of trends in claim frequency and severity?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Do you currently participate in a MPN program to control claim costs? (If yes, provide details.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	

COVID-19 PANDEMIC: If yes, provide details if applicable.

1. Has a detailed COVID-19 risk assessment been done?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Do you have a site-specific COVID-19/ATD Prevention Plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Are dedicated staff assigned to suspected/known COVID-19 patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. How many patients/residents/staff members have tested positive?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. How frequently are patients/residents screened for COVID-19?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. What control measures address reducing and/or preventing COVID-19?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. What Personal Protective Equipment (PPE) is provided to protect against COVID-19?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. How are suspected/positive COVID-19 patients/residents being isolated and managed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Is there any other information about your company, operations, or your practices that have been implemented which may have a positive impact on employee safety?

Insurance Code 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I understand that this is an evaluation form, **not** an application for insurance. It does not bind the State Fund to coverage of the above risk.

Signature

Title

Date

Printed Name