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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 ☐ No ☐	Comments:	
2. Are these businesses insured? Yes ☐ No ☐		
3. Do you have operations in other states? Yes ☐ No ☐		
4. Do you have any foreign travel exposures? (If yes, provide details concerning countries, duration and number of employees): Yes ☐ No ☐		

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 ☐ No ☐	
2. Pre-placement drug screening	Yes ☐ No ☐	
3. Periodic drug testing	Yes ☐ No ☐	
2. Criminal background checks	Yes ☐ No ☐	
3. Motor vehicle checks on drivers	Yes ☐ No ☐	
4. Job experience & certification requirements	Yes ☐ No ☐	
5. Minimum experience requirements	Yes ☐ No ☐	
6. New-hire orientation program	Yes ☐ No ☐	
7. Employee handbook	Yes ☐ No ☐	
8. Performance appraisals	Yes ☐ No ☐	
9. Wellness program in place	Yes ☐ No ☐	

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 ☐ No ☐			
2. Dental	Yes ☐ No ☐			
3. Vision	Yes ☐ No ☐			
4. Retirement	Yes ☐ No ☐			
5. Paid vacation days	Yes ☐ No ☐	Details		
6. Paid sick days	Yes ☐ No ☐	Details		
Do you offer the following benefits to the employees you send to clients?		% of Employer Contribution	% of Employees enrolled	Details
7. Medical	Yes ☐ No ☐			
8. Dental	Yes ☐ No ☐			
9. Vision	Yes ☐ No ☐			
10. Retirement	Yes ☐ No ☐			
11. Paid vacation days	Yes ☐ No ☐	Details		
12. Paid sick days	Yes ☐ No ☐	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 ☐ No ☐	
2. Do you complete job hazard assessments for all new clients or new tasks?	Yes ☐ No ☐	
3. Do you have procedures in place to eliminate clients for poor safety practices or loss experience?	Yes ☐ No ☐	
4. Do you review client's new worker orientation procedure?	Yes ☐ No ☐	
5. Do you review client's response procedures for emergency or accidents?	Yes ☐ No ☐	
6. Do you inspect worksite for safety "**prior**" to employee placement as well as on-going unannounced inspections?	Yes ☐ No ☐	
7. Do you or the client provide employees with description of the job assignment?	Yes ☐ No ☐	
8. Do you or the client provide safety training?	Yes ☐ No ☐	
9. What percentage of your client's patients are unable to "assist in the lift" during patient handling tasks?	Yes ☐ No ☐	

SAFETY PRACTICES/PROGRAMS – If yes, provide details.

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

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

5. Do you conduct employee safety meetings?	Yes ☐ No ☐	
6. Do you offer an employee safety incentive program?	Yes ☐ No ☐	
7. Do you offer modified duty/early return to work?	Yes ☐ No ☐	
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 ☐ No ☐	
9. Do you or your client enforce the use of lifting equipment practices?	Yes ☐ No ☐	
10. What is the frequency of Ergonomics or Back Safety Training?		Date of last training:
11. Do you or your client have a written Safe Patient Handling Plan?	Yes ☐ No ☐	
12. Do you or your client have a Workplace Violence Prevention Plan?	Yes ☐ No ☐	
13. Do you have a Heat Illness Prevention Program?	Yes ☐ No ☐	
14. Do you have a Respiratory Protection Program?	Yes ☐ No ☐	
15. Do you have a Driver Safety Training Plan or Fleet Safety Program?	Yes ☐ No ☐	
16. Do you have a Facility Emergency Evacuation Plan?	Yes ☐ No ☐	
17. Do you have written Lockout/Tag Out/Block Out procedures?	Yes ☐ No ☐	
18. Do you have a Hearing Protection Program/Annual Audiogram?	Yes ☐ No ☐	
19. Do you have an Aerosol Transmissible Disease (ATD) exposure control plan?	Yes ☐ No ☐	
20. Do you have ATD screening procedures?	Yes ☐ No ☐	
21. Do you have a Chemical Hygiene Plan for lab chemicals, wastes, disinfectants?	Yes ☐ No ☐	
22. Do you have a Sharps Policy forbidding recapping and/or re-sheathing needles?	Yes ☐ No ☐	
23. Do you offer pre- or post-exposure viral and bacterial vaccinations?	Yes ☐ No ☐	
24. Do you have an Exposure Control Plan for blood borne pathogens?	Yes ☐ No ☐	
25. Do you have an Enforcement of Universal Precautionary Policy for blood and infectious materials?	Yes ☐ No ☐	
26. Do you treat for communicable diseases (i.e., COVID-19, HIV, AIDS, etc.)?	Yes ☐ No ☐	
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 ☐ No ☐	
2. Do you have claims fraud investigation?	Yes ☐ No ☐	
3. Do you have established injury reporting procedures?	Yes ☐ No ☐	
4. Do you require all WC claims to be reported within 24 hours?	Yes ☐ No ☐	
5. Is there a set procedure for reporting claims which also includes a formal written accident investigation report?	Yes ☐ No ☐	
6. Do you conduct drug testing after an injury occurs? (If yes, provide details on procedure.)	Yes ☐ No ☐	
7. Do you have a process to identify claims frequency and claims trends? (If yes, provide details.)	Yes ☐ No ☐	
8. Do you conduct mid-term monitoring and reporting of trends in claim frequency and severity?	Yes ☐ No ☐	
9. Do you currently participate in a MPN program to control claim costs? (If yes, provide details.)	Yes ☐ No ☐	

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

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

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 _____