LCI
WORKERS' COMP

Medical Staffing Supplemental Questionnaire

Name of Applicant: _____

1. Any prior coverage? Yes ☐ No ☐
   If so, forward loss runs for the last 5 years.
2. Number of employees per class code: _____
   _____
3. Job description of each employee: _____
   _____
   _____
   _____
4. Any lifting of patients? Yes ☐ No ☐
   If so, what is the maximum weight lifted? _____
   If so, is team lifting practiced? Yes ☐ No ☐
   If so, are back braces worn? Yes ☐ No ☐
5. Are gloves, masks, gowns (PPE) worn when in direct physical contact with patients? Yes ☐ No ☐
6. Procedures for accidental needle punctures? _____
   _____
7. Are all employees current with vaccinations (Hepatitis B, TB, Flu, etc.)? Yes ☐ No ☐
8. Are any of the employees certified (LPN, CAN, RN, etc.)? Yes ☐ No ☐
   If so, please explain: _____
9. Type of training each employee receives: _____
   _____
   _____
10. Is group transportation provided? Yes ☐ No ☐
    If so, radius of travel? _____
    If so, are company vehicles used? Yes ☐ No ☐
11. Please provide copies of MVR's for all employees that may drive.
12. Please provide a copy of the company's standard operating procedures (SOP's) for things such as, but not limited to, hiring practices, second injury, and the drug and alcohol testing policy.
13. Please provide a copy of the company safety policy.

_____ _____

Signature of Applicant Date

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