Healthcare Staffing Supplemental Application

Application Information:

Applicant Name:	Broker Name:
Applicant Contact:	Broker Contact:
Years in Business:	Applicant Website:

1. Environment in which Healthcare Staffing is done (Please provide % of payroll for each that apply. Must total 100%):

   ________ Hospital ________ Nursing/Asst Living Home ________ Psychiatric Facility
   ________ Private Homes ________ Doctor's Office ________ Dental Office
   ________ Prison ________ Manufacturing Facility ________ School
   ________ Other: (Please describe) ____

2. Percentage of placements in the following occupations (Must total 100%):

   ________ RNs ________ LPNs ________ CNAs
   ________ Physician's Assistant ________ Homemaker/Home Aid ________ Lab Techs
   ________ Social Workers ________ Physical Therapists ________ Infusion Therapists
   ________ Speech Therapists ________ Occupational Therapist ________ Doctor/Dentist
   ________ Other: (Please describe) ____

3. Client/Employee Information:

   ________ # of Active Clients ________ # of Full Time Office Staff
   ________ # of W2s (last calendar year) ________ # of 1099s (last calendar year)

4. Does the Insured provide traveling nurses? ☐ Yes ☐ No
   Do the employees leave the state insured is headquartered? ☐ Yes ☐ No
   If yes, are all states listed on the acord with payroll? ☐ Yes ☐ No

5. Does the insured have a written safety program that includes the following?
   OSHA Bloodborne Pathogens standard? ☐ Yes ☐ No
   Personal Protective Equipment requirements? ☐ Yes ☐ No
   OSHA Needlestick Safety and Prevention? ☐ Yes ☐ No
   Is Hepatitis B vaccine series offered? ☐ Yes ☐ No

6. Does the Insured have a written Hazard Communication Policy? ☐ Yes ☐ No

7. Are employees required to lift of physically transfer patients? ☐ Yes ☐ No
   If so, describe safety training and company procedures for safe lifting:

   ____
   ____
   ____

8. Does the Insured provide housekeeping personnel to any medical facility? ☐ Yes ☐ No
9. Employee Screening (please check all that apply

☐ Pre-screening	☐ Signed Application	☐ Resume
☐ Interview	☐ Skills Testing	☐ I-9 Verification/E-Verify
☐ 100% Drug Testing	☐ By Client Request Drug Testing	☐ Reference Checks
☐ MVR Checks	☐ Criminal Background Checks	☐ Probationary Period
☐ Physicals	☐ License Verification	☐ Personality Assessment

10. Does the Insured screen each potential client for a safe work environment prior to accepting the assignment? ☐ Yes ☐ No

11. Does the Insured conduct pre-placement physical exams on all prospective hires involved in patient or client care? ☐ Yes ☐ No

12. Does the Insured have a Drug Free Workplace Program? ☐ Yes ☐ No

13. What percentage of the assignments are 14 weeks or longer? _______________

14. Does the Insured provide group transportation? ☐ Yes ☐ No

15. Are there any commonly owned entities that are not included in this submission? ☐ Yes ☐ No

16. Has the Insured's insurance been cancelled for non-payment of premium in the past 2 years? ☐ Yes ☐ No

By signing, we agree that all information included in this supplemental application is accurate at the time of completion and signature. We understand that if coverage is obtained based on this information and it is found to be inaccurate that coverage may be cancelled.

Producer Name, Date & Signature: ____

Insured Name, Date & Signature: ____