Assisted Living Workers Compensation Supplemental Application

Employer Name: ______________________________

Facility Information

1. Type of care facility: ______________________________
2. Number of licensed beds: ______________ Number of occupied beds: ______________
3. Describe the resident population including general overall health: ______________________________

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4. What percentage of the resident population requires assistance from staff when the resident transfers from one location to another? __________%
5. Is this a day or residential program? ☐ Day ☐ Residential
6. Is there a "lock down" component to the operation? ☐ Yes ☐ No
7. What types of activities or recreation do you have? ______________________________

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8. Do you provide transportation for residents? ☐ Yes ☐ No
   If yes, how many vehicles are used? ______________ How many authorized drivers? ______________
9. Are MVRs checked for authorized drivers? ☐ Yes ☐ No
10. Are certificates of insurance required for all independent contractors? ☐ Yes ☐ No
11. Is there a formal safety program in place? ☐ Yes ☐ No
12. Is there a safety committee that meets regularly? ☐ Yes ☐ No
13. Does the employer have an accident investigation program? ☐ Yes ☐ No
14. Will transitional duty be provided when appropriate work is available? ☐ Yes ☐ No
15. Has the employer been cited for any health or safety violations? ☐ Yes ☐ No

General Information

1. Does the applicant have a formalized drug testing program? ☐ Yes ☐ No
   If yes, check all that apply:

   ☐ Pre-Employment ☐ For Cause ☐ Random

   ☐ Suspicion ☐ Post-Accident

Applicant Signature

Name	Title
Signature	Date