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Medical Staffing Supplemental Application
Workers' Compensation

I. CONTACT INFORMATION

Insured Name: _____ Effective Date: _____

II. LOCATIONS WHERE SERVICES ARE PROVIDED: *(Must equal 100%)*

Private Home	____ %	Assisted Living Facility	____ %
Hospice	____ %	Doctor's Office	____ %
Physical Rehab Facility	____ %	Nursing Home	____ %
Hospital	____ %	Correctional Facility	____ %
Psychiatric/Behavioral Health Facility	____ %	Alcohol/Substance Abuse Facility	____ %
Other Facility (please specify):	____ %	_____	

III. TYPES OF PLACEMENTS: *(Must equal 100%)*

Registered Nurse	____ %	Licensed Practical Nurse/Vocational Nurse	____ %
Certified Nurse Aid/Home Health Aide	____ %	Sitters/Companions (non-medical)	____ %
Homemaker (non-medical)	____ %	Nurse Practitioner	____ %
Physician Assistant	____ %	Social Worker/Counselor	____ %
Psychologist	____ %	Respiratory Therapist	____ %
Technicians (Radiology, Phlebotomy, etc)	____ %	Speech/Occupational Therapist	____ %
Physical Rehabilitation Therapist	____ %	Clerical Administrative	____ %
Other (please specify):	____ %	_____	

IV. ADDITIONAL QUESTIONS

Do you offer 24-hour care, or do you provide live-in care? ☐ Yes ☐ No

24-hour care? ☐ Yes ☐ No If "Yes", % of total services: ____ %

Live-in care? ☐ Yes ☐ No If "Yes", % of total services: ____ %

Are there shifts over 10 hours? ☐ Yes ☐ No

If "Yes", please explain: _____

Are documented proper procedures for safe lifting provided to employees? ☐ Yes ☐ No

If "Yes", please explain: _____

If a formal safety program is in effect, does it include the following elements? ☐ Yes ☐ No

Patient Handling/Transfer Training ☐ Yes ☐ No

Blood Borne Pathogen ☐ Yes ☐ No

Combative Patient Training ☐ Yes ☐ No

Do you pay any employees via 1099? ☐ Yes ☐ No

Are they covered under your Work Comp Policy? ☐ Yes ☐ No

If "Yes", how many or what % _____

If "No", do you obtain certificates of insurance on each? ☐ Yes ☐ No

_____ _____

Signature of Insured Signature of Broker

_____ _____

Print Name/Title Print Name/Title