

Physician Questionnaire

Supplemental to
Fully Completed ACORD 130 Workers' Compensation Application

Applicant Name	Effective Date
FEIN	Website

Description of Operations

Operations	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a Non-Profit organization?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do any employees work 24-hour shifts?
	How many independent contractors / 1099 employees used?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you verify workers comp coverage for independent contractors?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you lease out employees or provide temp staffing to outside clients?
_____ %	If yes, what is the % of payroll leased or temp staffing to others?

COVID-19	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Screen workers and patients for signs and symptoms
<input type="checkbox"/> Yes <input type="checkbox"/> No	Require workers and patients wear proper masks
<input type="checkbox"/> Yes <input type="checkbox"/> No	Regularly clean and disinfect surfaces, rooms and workstations
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ensure all workers have proper personal protective equipment (PPE)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Instruct sick workers to stay at home

Hiring Practices	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Written Application
<input type="checkbox"/> Yes <input type="checkbox"/> No	Written Job Description
<input type="checkbox"/> Yes <input type="checkbox"/> No	Background / Reference Check
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-Hire Drug Testing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-Hire Physical Fitness Test
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are certifications/ licenses verified?

Safety Practices		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Formal Injury & Illness prevention program	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Formal Return to Work program	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Quarterly (or more) safety meetings	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Quarterly (or more) safety training	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Safety Incentive Plan	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are employees required to wear non-slip shoes?	

Management Practices, Operations, Loss Control, Claims Handling & Benefits		
_____ #	Number of years this medical practice has been operating?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this medical practice owned by an outside management company?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a FT risk/safety mgr. employed whose job is 50%+ safety related?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a post-accident drug testing program for all workplace injuries?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a formal accident investigation and claims reporting process?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do more than 50% of employees receive group health that is 50% employer paid?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you provide vacation and sick time to all employees?	
_____ %	Percent of employee turnover during past year.	

Safety Program – Check any that apply		
<input type="checkbox"/> Personal Protective Gear	<input type="checkbox"/> Combative Patient Training	<input type="checkbox"/> Safety Committee
<input type="checkbox"/> Lifting Procedures & training	<input type="checkbox"/> Blood Borne Pathogen Training	<input type="checkbox"/> New Employee Orientation
<input type="checkbox"/> Needle disposal (OSHA compliant)	<input type="checkbox"/> Contaminated Waste/Hazardous products disposal (OSHA compliant)	<input type="checkbox"/> Other (please describe)