

Commercial Janitorial Services Supplemental Application

Workers Comp Supplemental Application – August 2018 Edition

Applicant Name: _____	Eff Date: _____
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Fein #: _____	Website Address: _____
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SAFETY PROGRAM – WORK PREMISES, ENVIRONMENT, AND BENEFITS

Are owners active in daily operations?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, are they excluded from coverage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Corporation – Does Officer or Director have 15% minimum ownership?	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>		
Partnership or LLC – Is the excluded person a General Partner or Managing Member?	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>		
Active formal written safety program?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Active safety incentive program?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, does it include all employees?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What type of incentive? _____	Average Hourly Wage? _____		
Do employees receive safety orientation & training?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes: Formal/Documented <input type="checkbox"/> Informal <input type="checkbox"/>	
Are safety meetings conducted?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	
Return to Work Program/Modified Duty?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please describe _____	
Does Employer Provide Group Medical?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Name of Provider? _____	

HIRING PRACTICES

Written Employment Application?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pre Hire Drug Testing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Reference Checks?	Yes <input type="checkbox"/> No <input type="checkbox"/>	I9 Verification on All New Hires?	Yes <input type="checkbox"/> No <input type="checkbox"/>
MVR Checks?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pre Employment Physicals?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Driver Acceptability Standards?	Yes <input type="checkbox"/> No <input type="checkbox"/> - If Yes, Provide Details: _____		

JANITORIAL CLEANING SERVICES

* Includes operations such as vacuuming, dusting, wastebasket trash pick-up, floor & rug cleaning, restroom clean-up

CHECK ALL CUSTOMERS THAT APPLY – Provide % of total sales

Offices ___ %	Hotels ___ %	Apts/Condos ___ %	Retail ___ %	Hospitals/Medical Facilities ___ %	Schools: ___ %
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SERVICES PROVIDED: (Check All That Apply Below)

<input type="checkbox"/> General Cleaning *	<input type="checkbox"/> Carpet Cleaning	<input type="checkbox"/> Floor waxing	<input type="checkbox"/> Exterior Window Cleaning – Over single story
<input type="checkbox"/> Exterior Cleaning Services?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Please Describe: _____	
<input type="checkbox"/> Construction Site Cleanup?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Crime Scene Cleanup	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sub-Contractors Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Annual Cost? _____		Certificates Obtained? Yes <input type="checkbox"/> No <input type="checkbox"/>
Manual Lifting or Moving > 25 Lbs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Please describe: _____	
Any Cleaning Supplies Used Other Than Standard Commercial?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Describe: _____	
			If Yes, Are MSDS Available? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do Employees Work in Teams?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Avg # of EE's per Team? _____	Maximum # of EE's per Team? _____
Use Co Owned Vehicles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vehicles Taken Home?	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Family Use Policy? Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Do Employees Use Personal Vehicle?	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>		Require Proof of Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Inspect Personal Vehicles?	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	If Yes, How Often?	Proof of Maintenance? Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Driving Guidelines for Cell Phone Usage & Seatbelts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Please describe: _____	
Hours of Operation: _____ to _____	Avg # of Jobs per Day? _____	Radius of Operations: _____	24 Hr? Yes <input type="checkbox"/> No <input type="checkbox"/>

Completed by: _____	Date: _____	Email Address: _____
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