

Trinidad Navarro  
Insurance Commissioner



Delaware Department of Insurance

## **Workplace Safety Program Questionnaire Submission Tips**

This Questionnaire (PDF) allows for you to complete this form online but in order for the *Submit* button at the bottom of the last page to work properly you must use Internet Explorer as your web browser.

If you are using any web browser other than Internet Explorer (Firefox, Chrome, Safari, etc.) you will need to download the Questionnaire, complete it and then submit it via email (or fax).

If you do not receive a confirmation email from a Workplace Safety Program staff member within 3 full business days of submitting your Questionnaire, please call 302-674-7377 to confirm that your form was received.

Please submit your inspection fee by mail and include the top page of your questionnaire with your check. See the fee schedule page for additional instructions.

Thank you,

Delaware Department of Insurance

Workplace Safety Program

**STATE OF DELAWARE  
WORKPLACE SAFETY PROGRAM QUESTIONNAIRE**

Please submit your application **five months prior** to your policy renewal date.  
PLEASE SUBMIT YOUR INSPECTION FEE at the time of application.

**GENERAL INFORMATION**

Business Name: \_\_\_\_\_

Attention (Mr., Mrs., Dr., Name ): \_\_\_\_\_

Job Title: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Is any off-site work done?  Yes  No If yes, please complete **Job Site Addendum**.

Do you have a Drug Free Program?  Yes  No If yes, please complete **Drug Free Program Addendum**.

Hours of Operation: \_\_\_\_\_

Are you seasonal?  Yes  No If yes, please provide the dates you are open for business:

\_\_\_\_\_

Describe Operation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Delaware** Location(s): \_\_\_\_\_

\_\_\_\_\_

**Department Use Only**

RENEWAL DATE: \_\_\_\_\_ FILE#: \_\_\_\_\_ #OF YEARS: \_\_\_\_\_ PERCENTAGE \_\_\_\_\_

INSPECTION DUE DATE: \_\_\_\_\_ CHECK: \_\_\_\_\_ AMOUNT: \_\_\_\_\_

AMOUNT PAID LAST YEAR: \_\_\_\_\_ LOCATION (S): \_\_\_\_\_ INSPECTION(S): \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## WORKPLACE SAFETY INSPECTION FEE SCHEDULE\*

For Property Management, Artisans, and Contractors (General, Building, Custodial, Lawn Service, etc.):

EFFECTIVE AS OF NOVEMBER 1, 2003

	1 <sup>st</sup> YEAR	ALL CONSECUTIVE YEARS
Home Base plus 2 Sites or Less	\$700	\$350
Home Base plus 3 to 5 Sites	\$1,000	\$500
Home Base plus 6 to 10 Sites	\$1,500	\$750
Home Base plus 11 to 15 Sites	\$2,000	\$1,000
Home Base plus 16 or More	\$3,000	\$1,500

For Most Other Businesses:

	1 <sup>st</sup> YEAR	ALL CONSECUTIVE YEARS
One Building	\$300	\$150
One Building Plus CDLs	\$400	\$200
Two Buildings/ Car Dealerships/Country Clubs	\$600	\$300
Four Buildings	\$1,200	\$600
Six Buildings	\$1,800	\$900
Eight Buildings	\$2,400	\$1,200
Ten Buildings	\$3,000	\$1,500

*Only Delaware work sites are eligible for the Workplace Safety Program. The safety credit applies to Delaware premiums in multi-state policies.*

### **FEES MAY BE ADJUSTED UNDER CERTAIN CIRCUMSTANCES**

Please send in a minimum of \$150 if you are unsure of your fee. You will be invoiced for the balance due or refunded, if necessary upon completion of your inspection.

\*Not applicable for inspections conducted by workers compensation insurance carriers.

Make your check payable to Delaware Insurance Department.

Sign and date your check.

The amount must be written out in type-written words as well as numbers.

**EMPLOYEE, WORKPLACE INJURY, AND WORKERS COMPENSATION CLAIMS DATA:**

Number of full-time employees: \_\_\_\_\_ Part-time employees: \_\_\_\_\_

Have you had any Workers Compensation Claims in the last 36 months?  Yes  No

If yes, please indicate which year (s): \_\_\_\_\_

Please provide an estimate of lost workdays\*: \_\_\_\_\_

\*(Begin counting the day after the incident occurs. If a single injury involves both days away from work *and* days of restricted work activity, enter the total days for each. Stop counting once the total of either or the combination of both reaches 180 days for that injury. For clarification please see OSHA Recordkeeping at [www.osha.gov](http://www.osha.gov))

***The following information will be explicitly considered in determining whether you receive your Workplace Safety Credit in accordance with the new Delaware law:***

*Workplace injuries which have occurred during the last three years:  
(use additional paper if needed)*

Date	Specific Nature of Injury	Fines or Findings Relating to Workplace Safety	Safety Measures Taken by Employer	MDA**

***\*\*Please have all applicable Modified Duty Availability Reports available for your inspector to review.***

***The requirements of 2013 House Bill 175 regarding the Workplace Safety Program remain in effect. In addition to hazard recognition observations based on the physical walk through of your workplace and abatement of previously made recommendations, where applicable, three years of workplace injury data will now also be considered when determining if you will be awarded the Workplace Safety Program Credit. For compliance, please ensure all information is filled out completely and accurately.***

## **IMPORTANT INFORMATION – PLEASE READ CAREFULLY**

The purpose of a Workplace Safety Program inspection is solely to determine if the participating business qualifies for the Delaware Workplace Safety Program insurance premium discount. Conditions considered include, but are not limited to, the following: an effective health and safety program, adequate and effective employee training, identification and elimination of potential hazardous conditions, and three years of workplace injury data. Although the inspector might cite Occupational Safety & Health (OSHA) standards, other regulations or guidelines, the Delaware Workplace Safety Program is not the same as an OSHA inspection. The purpose is not to determine compliance with OSHA or any other safety regulations or standards of care; it is simply to determine whether the health and the safety of employees are an important part of businesses participating in the program and that hazards are routinely and regularly identified and **corrected**.

No liability or responsibility is assumed by the person or entity preparing the report or performing the inspection, for any injuries to employees, subcontractors or other persons injured at the businesses participating in the Delaware Workplace Safety Program. It remains the sole responsibility of the participating business to assure their premises are safe for their employees, subcontractors and all other persons at their businesses and facilities. No contractual relationship exists between the parties performing the inspections and preparing the reports and the participating businesses, their employees, subcontractors and all other persons on their premises.

**DELAWARE EMPLOYERS' WORKPLACE HEALTH AND SAFETY INCENTIVE PROGRAM**

**I. SAFETY PROGRAMS/PHILOSOPHY**

1. Do you have a complete safety program with a written policy statement?  Yes  No  
(Please attach a copy of the index; have complete copy available for the inspector)
2. Who is your Safety Director/Coordinator? \_\_\_\_\_
3. Do you have a safety committee?  Yes  No
4. How often do you conduct safety meetings? \_\_\_\_\_
5. Do you follow OSHA records keeping procedures?  Yes  No  
(Please have your latest OSHA 300/300A log available.)
6. Do you maintain written programs on the following?
- a. Emergency Plan and Fire Prevention Plan
  - b. Occupational Noise Program
  - c. Tag/Lockout Program
  - d. Chemical Hazard Communication (MSDS)
  - e. Driver/Vehicle Safety
  - f. Industrial Truck Operators' Program
  - g. Respiratory Protection Program
  - h. Personal Protective Equipment/Clothing
  - i. Lifting/ Back Safety
  - j. Ergonomics
  - k. Blood Borne Pathogens
  - l. Portable ladders and stairway safety training
  - m. Scaffold Safety
  - n. Fall Protection
  - o. Cranes/Hoists (material/personnel)
  - p. Welding and Cutting
  - q. Steel Erection
  - r. Excavations
  - s. Aerial Lifts
  - t. Confined Space
  - u. Drug & Alcohol\* **If yes, please complete Drug Free Program Addendum.**

7. Which chemicals are commonly used in the workplace?

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8. Please check any of the following tools you use to train your employees on safety:

- |  |   |
|--|---|
| <input type="checkbox"/> a. On the job supervised training | <input type="checkbox"/> d. Safety Consultant       |
| <input type="checkbox"/> b. Videos                         | <input type="checkbox"/> e. Insurance Agent/Carrier |
| <input type="checkbox"/> c. Safety Seminars                | <input type="checkbox"/> f. Other _____             |

9. What actions have you taken within the last 6 to 12 months to enhance a safer work environment?

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## II. FIRST AID

1. Are emergency phone numbers posted in prominent places?  Yes  No
2. Do you keep first aid supplies highly visible, close to employees, inspected and replenished continuously?  Yes  No
3. Do you have an AED kit on hand?  Yes  No
4. Are batteries and chest pads current?  Yes  No
5. Who is trained in First Aid/CPR? \_\_\_\_\_  
Is training Red Cross approved?  Yes  No
6. Do you have ANSI approved eyewash/emergency shower facilities?  Yes  No
7. Do employees work outside?  Yes  No
8. If applicable, are first aid and fire extinguishers provided on job sites?  Yes  No

## III. HOUSEKEEPING AND MAINTENANCE

1. Are any electrical cords strung across walkways?  Yes  No
  - a) If so, are they properly marked and guarded?  Yes  No
2. Are any loose floor mats safety-edged?  Yes  No
3. Any worn or frayed carpet, open carpet seams or curled edges?  Yes  No
4. Any holes, uncovered drains, protruding nails, splinters, loose boards or projections in floors?  Yes  No
5. Are there any false floors or platforms used to provide dry standing & walking surfaces?  Yes  No
6. Are all floors free of debris, lint, dust, oil, grease, paint or spray residue, granular materials, sand, mud, ice or other slippery traction-robbing material?  Yes  No
7. Is there continual good housekeeping, including **immediate cleanup of unavoidable spills**?  Yes  No
8. Is lighting adequate for all operations?  Yes  No
9. Do you have emergency lighting?  Yes  No
10. What type of sprinkler and/or smoke detection system do you have? \_\_\_\_\_
  - a) When was it last tested? \_\_\_\_\_
  - b) Do you have specific storage areas? \_\_\_\_\_
  - c) Is stock stored 18" below sprinkler heads? \_\_\_\_\_
11. Are all exits clearly marked and unobstructed?  Yes  No
12. Are there frequent refuse pickups?  Yes  No



#### IV. AUTOMOBILE

This section applies if you have employees who drive cars or trucks as a regular part of their work; and where employees drive their own cars on company business.

1. Are employees taught how to inspect vehicles/equipment before use?  Yes  No
2. Do employees required to operate motor vehicles participate in a Defensive Driving Program?  Yes  No
3. Are scheduling & driving speeds reflective of this?  Yes  No
4. Are employees required to have CDLs?  Yes  No
5. Are Motor Vehicle Reports (MVR's) requested on all drivers at regular intervals?  Yes  No
6. Do you have a written drug/alcohol policy program?  Yes  No
7. Are MVR's requested on all prospective employees, covering all states in which they have been licensed?  Yes  No
8. How do you enforce the Delaware cell phone/texting law? \_\_\_\_\_
9. Are employees required to use seatbelts?  Yes  No
10. Are horns and back up alarms provided and operable on equipment/vehicles that require them?  Yes  No
11. How often are driver training and safety meetings held? \_\_\_\_\_
12. What actions are taken in connection with accidents or violations, and have they proven effective? Describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Are there any time pressures inherent in your operations?  Yes  No  
If "yes", describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Are fully stocked first aid kits and fire extinguishers maintained on vehicles?  Yes  No

#### V. GENERAL INFORMATION

1. When did your insurance carrier last conduct an engineering & loss control inspection of your premises and operations. Date: \_\_\_\_\_
2. What worker's compensation recommendations have been made by your insurance carrier? \_\_\_\_\_  
\_\_\_\_\_
3. Have they been complied with?  Yes  No
4. Has an OSHA inspection ever been done?  Yes  No
  - a) If so, were any recommendations made, citations issued; fines or penalties levied? If "yes", explain.  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

5. What regulatory authorities inspect your operations?

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a) How often? \_\_\_\_\_

(Mr., Mrs., Dr.), Name of person completing this questionnaire: \_\_\_\_\_

Employer: \_\_\_\_\_

Job Title: \_\_\_\_\_

Date: \_\_\_\_\_

If not an employee of company, please provide relationship: \_\_\_\_\_

Information Verified by: \_\_\_\_\_

(Management Level Employer Representative)

Please visit our website at: [insurance.delaware.gov](http://insurance.delaware.gov)

For questions, call: (302) 674-7377

Fax #: (302) 736-7910

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