

**STATE OF DELAWARE  
WORKPLACE SAFETY PROGRAM QUESTIONNAIRE**

Please submit your application **5-7 months prior (no later than 5 months prior)**  
to your policy renewal date.

PLEASE SUBMIT YOUR **INSPECTION FEE** at the time of application.

**GENERAL INFORMATION**

**HOW DID YOU HEAR ABOUT THE PROGRAM?** \_\_\_\_\_

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

Doing Business As: \_\_\_\_\_

Point of Contact (Mr., Mrs., Dr., Name): \_\_\_\_\_

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

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

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

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

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ 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 date you are open for business:

\_\_\_\_\_

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

**Delaware Locations:** \_\_\_\_\_

\_\_\_\_\_

**Department Use Only**

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

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

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

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

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

**Complete chart below. DO NOT SEND LOSS COSTS REPORTS or any other report  
containing personally identifiable information!**

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  
discount in accordance with current Delaware law:***

*Workplace injuries which have occurred during the last 3 years:  
(use additional paper if needed)*

Date	Specific Nature of Injury	Fines or Findings/Root Cause	Measures Taken by Employer to Prevent Recurrence	MDA**

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

**For compliance, please ensure all information is filled out completely and accurately.  
For additional information see [19 Delaware Code Chapter 23 section 2379](#).**

# 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. Person most responsible for safety: \_\_\_\_\_
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/hazardous materials 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? \_\_\_\_\_
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  
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 and walking surfaces?  Yes  No
6. Are all floors free of debris, ink, 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?  Yes  No
  - c) Is stock stored 18" below sprinkler heads?  Yes  No
11. Are all exits clearly marked and unobstructed?  Yes  No

**IV. AUTOMOBILE**

This section applies if you have employees who drive cars or trucks as a regular part of their work duties 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 that are required to operate motor vehicles participate in a Defensive Driving Program?  Yes  No
- 3. Are employees required to have CDL's?  Yes  No
- 4. Are Motor Vehicle Reports (MVR's) required on all drivers at regular intervals?  Yes  No
- 5. Do you have written drug/alcohol policy program?  Yes  No
- 6. Are MVR's requested on all prospective employees, covering all States in which they have been licensed?  Yes  No
- 7. How do you enforce the Delaware cell phone/texting law?  Yes  No
- 8. Are employees required to use seatbelts?  Yes  No
- 9. Are horns and back up alarms provided and operable on equipment/vehicles that require them?  Yes  No
- 10. How often are drive training and safety meetings held? \_\_\_\_\_
- 11. What actions are taken in connection with accidents or violations, and have they proven effective? Describe. \_\_\_\_\_  
\_\_\_\_\_
- 12. Are fully stocked first aid kits and fire extinguishers maintained on vehicles?  Yes  No

**V. GENERAL INFORMATION**

1. What was the date that your insurance carrier last conducted an engineering & loss control inspection of your premises and operations? \_\_\_\_\_
  - a) What workers compensation recommendations have been made by your insurance carrier? \_\_\_\_\_
  - b) Have the recommendations been addressed?  Yes  No
  
2. Has an OSHA inspection ever been done?  Yes  No  
If yes, were any recommendations made, citations issued, and/or fines or penalties levied? Please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
3. What regulatory authorities inspect your operations and how often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of the person completing this questionnaire: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Job Title: \_\_\_\_\_  
If not an employee of company, please provide relationship: \_\_\_\_\_  
Information Verified by (Management Level Employer Representative): \_\_\_\_\_  
Date: \_\_\_\_\_

For more information, call **(302) 674-7377**.

Submit applications or questions by fax, mail, or email:  
Delaware Department of Insurance  
Attn: Workplace Safety  
1351 West North Street, Suite 101  
Dover, DE 19904

(302) 736-7910 Fax  
[safety@delaware.gov](mailto:safety@delaware.gov)