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 Location/s (List ALL Delaware addresses covered under THIS policy)**:**

_____

_____

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)

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?
_____
_____
_____
_____
_____
_____

8. Please check any of the following tools you use to train your employees on safety:
☐ a. On the job supervised training
☐ b. Videos
☐ c. Safety Seminars
☐ d. Safety Consultant
☐ e. Insurance Agent/Carrier
☐ f. Other _____

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

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, 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