TPM Total Program Management
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HOSPITAL/HEALTH SERVICES FACILITIES SUPPLEMENTAL APPLICATION

Insured: _____ Eff Date: _____ FEIN NO. _____
Contact Name & Title: _____ Tel. No.: _____ Fax No.: _____

INSURED HISTORY:

Years in business:_____ Facility Designed for: Hospital: ___ Immediate Care: ___
Other: (indicate): _____ Total # of beds: (per facility/location): _____

Facility Information:
Not for profit: ___ For profit: ___ Medicare Certified: ___ Medicaid certified: ___ TJC accredited: ____
Out of state exposure: ☐ Yes ☐ No If yes, name of states: _____ Foreign Travel: ☐ Yes ☐ No

Licenses for your facility:
State: _____ Type: _____ License#: _____ License period: _____
Other: _____ Type: _____ License#: _____ License period: _____

Are any licenses conditional or restricted?: Yes ___ No ___ If 'yes', explain: _____
Have any of your licenses been suspended; revoked or placed under probation in the past 5 years?: Yes ___ No ___
If 'yes' to the above; explain: _____

Are there specialized units for:
Alcohol/Drug Abuse?: ☐ Yes ☐ No If 'yes', # staff assigned on avg. to this specialized unit: _____
Psychiatric Care?: ☐ Yes ☐ No If 'yes', # of staff assigned on avg. to this specialized unit: _____
Airlift Trauma Center?: ☐ Yes ☐ No If 'yes'; # of staff assigned on avg. to this specialized unit: _____

Emergency Conveyance Information:
Ambulance: # of units: _____ Avg. # of employees occupying &/or driving: _____
Fixed wing aircraft: # of units: _____ Avg. # of employees occupying &/or operating: _____
Helicopter: # of units: _____ Avg. # of employees occupying &/or operating: _____
Other* (*specify:): _____

Employment Information:

Present number of employees: Full-time employees _____ Part-time _____ Seasonal _____ Volunteers_____
Percent of employee turnover in the last 12 months Full-time _____ Part-time _____
Employee staffing expectation over the next 12 months Full-time _____ Part-time _____
Benefits provided – are ALL employees eligible ☐ Yes ☐ No If not then who is eligible? _____

			% paid by employer
Group Health	☐ Yes	☐ No	_____
Paid sick leave	☐ Yes	☐ No	_____
Retirement / Pension Plan	☐ Yes	☐ No	_____

Name of Healthcare provider: _____

Does this facility use outside labor &/ or vendors for their healthcare business operations?: Yes__ No__
If "Yes" are Certificates of Insurance obtained for any subcontracted outside vendors?: Yes__ No__
If "No" explain:_____
Please indicate the person(s) responsible for maintaining these records:_____Title:_____

Does the applicant intend to have workers compensation insurance extend to cover non-compensated volunteer employees, if allowed by their state? ☐ Yes ☐ No If 'yes', complete the following:

Description of duties	No.of Volunteers	Total Annual Hours Worked

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Is the applicant in compliance with CDC's and OSHA's standards for blood-borne pathogens and infectious disease?:
☐ Yes ☐ No If 'no'; explain: _____

Are written and enforced loss control procedures in effect for the following?:
Proper lifting techniques: ☐ Yes ☐ No
Handling of bodily fluids: ☐ Yes ☐ No
Radiation exposures: ☐ Yes ☐ No
Slip and Fall Prevention Program in place ☐ Yes ☐ No
Hazardous Materials/Communicable Disease program in place ☐ Yes ☐ No
Accident investigation program in place ☐ Yes ☐ No
Are safety syringes &/or "needle-less" devices being used?: ☐ Yes ☐ No Other: specify: _____
Are latex gloves provided and utilized in the daily operations?: ☐ Yes ☐ No If 'no'; explain: _____
*Explanation of any "No" responses indicated above: _____

Indicate the safety activities currently established and practiced regularly:

Return to light duty plan	☐ Yes	☐ No	Includes full wages	☐ Yes	☐ No
Return to Full-time modified work plan	☐ Yes	☐ No			
Designated Full-time safety director	☐ Yes	☐ No	Name: _____		
Safety meetings held for all employees	☐ Yes	☐ No	Frequency of meetings _____		
Safety training held for all employees	☐ Yes	☐ No	Incentive program for employees	☐ Yes	☐ No

HIRING PRACTICES:

Employment application	☐ Yes	☐ No	Drug/substance abuse	☐ Yes	☐ No
Reference checks	☐ Yes	☐ No	Written disciplinary procedure	☐ Yes	☐ No
Motor Vehicle Record check	☐ Yes	☐ No	Pre/Post employment physical	☐ Yes	☐ No
Volunteer labor used	☐ Yes	☐ No	Certificates of insurance obtained	☐ Yes	☐ No
Temporary labor used	☐ Yes	☐ No	Orthopedic back test	☐ Yes	☐ No

PAYROLL AND PREMIUM HISTORY:

Payroll:		Premium:		Mod:	
	Current Yr. _____		Current Yr. _____		Current Yr:_____
1st	Prior Yr. _____	1st	Prior Yr. _____	1st	Prior Yr._____
2nd	Prior Yr._____	2nd	Prior Yr._____	2nd	Prior Yr._____
3rd	Prior Yr._____	3rd	Prior Yr._____	3rd	Prior Yr._____

EXPOSURE INFORMATION – FIXED LOCATION - EMPLOYEES

Location #	Payroll	Total # of Employees	# of Shifts	Maximum # of Employees Per Shift

	$			
	$			
	$			

Signature:_____ Title:_____ Date:_____