



## Contractor Supplemental Questionnaire

General Information	
Business Name:	Primary Contact:
Contractor License #:	SIF Policy/Application #:
Phone:	Email:

Operations		
Indicate the type of work performed:		
<input type="checkbox"/> Exterior	<input type="checkbox"/> Interior	<input type="checkbox"/> Service/Repair
<input type="checkbox"/> New Construction	<input type="checkbox"/> Remodeling	<input type="checkbox"/> Restoration
If exterior work is performed, what is the maximum height? _____		
Is any work performed below grade?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is any work performed in confined spaces?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has OSHA visited or cited you in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there any out of state or overnight travel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do any employees work from home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there paid sick leave?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a group medical insurance plan provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are employees required to drive (such as to job sites or to pick up supplies)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other		
Is there group transportation provided to employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, number of employees transported per vehicle? # _____		
What is the radius of travel? # _____ miles		
Do you have a safe driving policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are driving records reviewed annually?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Employees & Hiring Practices		
Number of full-time employees: _____		Number of part-time employees: _____
How are employees paid?	<input type="checkbox"/> Hourly	<input type="checkbox"/> Salary <input type="checkbox"/> Piece Rate <input type="checkbox"/> Other
Do you use a written employment application?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are criminal background checks performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is pre-employment drug testing performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a Drug-Free Workplace Program, meeting Idaho Code 72-1701 through 72-1715?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are work references checked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are pre/post-employment physicals required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are pre-existing injuries documented?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is formal training provided to new employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is training/certification required for equipment operators?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are subcontractors used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, are certificates of insurance obtained and kept?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are updated certificates received annually?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What percentage of work is subcontracted? _____%		
What type of work is subcontracted? _____		

Safety Programs & Practices		
Is there a formal, written safety program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, is the plan reviewed with employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a designated safety professional?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, what is the name of the professional? _____		
Is there a safety committee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, are committee meetings held regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is the frequency of meetings?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other
Are formal accident investigations performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there an active safety incentive program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, are all employees included in the program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do employees receive safety training?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, is the training formal & documented?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please check all trainings/programs you participate in:		
<input type="checkbox"/> Safe Driving Program <input type="checkbox"/> Excavation Program <input type="checkbox"/> Fall Protection Program <input type="checkbox"/> Respiratory Program <input type="checkbox"/> Equipment Training (including forklifts)		
Is personal protective equipment (PPE) provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is proper wear of PPE strictly enforced?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does all equipment have proper guarding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is the condition of equipment/machinery?	<input type="checkbox"/> New	<input type="checkbox"/> Good
	<input type="checkbox"/> Average	
Who is responsible for equipment/machinery maintenance? _____		
Are equipment inspections & maintenance documented?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Medical Controls		
Have you selected and do you use a preferred medical provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is a return-to-work program available to injured workers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is light/modified duty provided to injured workers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is CPR/First Aid training provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there an emergency action or disaster plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is the average distance in miles from medical care? _____ miles		

\_\_\_\_\_  
Signature of owner

\_\_\_\_\_  
Date