

advantage



WELLNESS

## INDUSTRIAL NEEDS QUESTIONNAIRE

|                   |  |
|-------------------|--|
| Date              |  |
| Firm Name         |  |
| Name & Position   |  |
| Telephone & Email |  |
| Address           |  |
| City/State/Zip    |  |

1. Over the past three years, has your work-related injury rate:

- Decreased  
 Increased  
 Remained about the same  
 Unsure

Why? \_\_\_\_\_  
\_\_\_\_\_

2. In the past three years, has the cost of your work-related injuries:

- Decreased  
 Increased  
 Remained about the same  
 Unsure

Why? \_\_\_\_\_  
\_\_\_\_\_

3. How many employees are at your facility?

- Full time  Part time

4. Over the last three years, have the total number of employees at your firm:

- Decreased  
 Increased  
 Remained about the same

5. Is your company self-insured?

- Yes  
 No

6. Are you aware of the amount you spend annually on workers' compensation injuries?

\$ \_\_\_\_\_ Last Year  
\$ \_\_\_\_\_ Two Years Ago  
\$ \_\_\_\_\_ Three Years Ago

7. What are your annual workers' compensation insurance premiums for the following years?

\$ \_\_\_\_\_ Last Year  
\$ \_\_\_\_\_ Two Years Ago  
\$ \_\_\_\_\_ Three Years Ago

8. Have you experienced any time loss work injuries:

\_\_\_\_\_ Last Year. If yes, how many days? \_\_\_\_\_  
\_\_\_\_\_ 2 Years Ago. If yes, how many days? \_\_\_\_\_  
\_\_\_\_\_ 3 Years Ago If yes, how many days? \_\_\_\_\_

9. In which departments/area do the majority of your injuries occur?

\_\_\_\_\_  
\_\_\_\_\_

10. What type of injury is most likely to occur at your facility?

\_\_\_\_ Upper Extremity Cumulative Trauma  
\_\_\_\_ Back/Neck injuries  
\_\_\_\_ Cut/abrasion  
\_\_\_\_ Hearing Loss  
\_\_\_\_ Others-explain \_\_\_\_\_

11. Over the past three years, have your medical claims/medical premiums:

\_\_\_\_ Decreased  
\_\_\_\_ Increased  
\_\_\_\_ Remained about the same  
\_\_\_\_ Unsure

12. Does your company utilize any of the following?

\_\_\_\_ Company Doctor (Full time or part time)  
\_\_\_\_\_ On-site \_\_\_\_\_ At his/her own clinic  
\_\_\_\_ Occupational Health Nurse  
\_\_\_\_\_ Full time or \_\_\_\_\_ Part time  
\_\_\_\_\_ On-site or \_\_\_\_\_ Consultant  
\_\_\_\_ Safety Supervisor/Coordinator  
\_\_\_\_\_ Full time or \_\_\_\_\_ Part time  
\_\_\_\_ Other agencies to assist Human Resource

\_\_\_\_\_  
\_\_\_\_\_

13. Does your company have a safety committee?

\_\_\_\_ Yes, its function is: \_\_\_\_\_  
\_\_\_\_ No

14. Does your company investigate reported injuries to prevent future problems?

- Yes  
 No

15. Does your company have a written accident prevention program?

- Yes  
 No

16. Does your company currently make efforts to educate and motivate your management and supervisory personnel about the practicality and cost effectiveness of safety and prevention methods?

- Yes  
 No  
 Would like to do more

17. Does your company currently make efforts to educate and motivate your workers in methods of preventing and reducing work-related injuries?

- Yes  
 No  
 Would like to do more

18. How would you rate your employee's moral and company pride?

- Great  Good  Poor  Unsure

19. Does your company currently incorporate ergonomic considerations in your safety and prevention program?

- Yes  
 No  
 Would like to do more

20. Does your third party insurer/TPA provide incentives or assistance with health and wellness at your company?

- Yes  
 No  
 Unsure

Thank you for completing this INQ. Please return and include Work Comp Loss Run Reports and OSHA 300 Logs for the last 3 years to Advantage Wellness.

Advantage Wellness  
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Waconia, MN 55387  
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