

This is an optional SHS Questionnaire which replaces all other SHS questionnaires. ACORDS are still required.

Name of organization: _____

Website address: _____ *If you do not have a website, attach brochure and detailed description of daily activities of organization.*

A. Facilities and Operations

1. Indicate number of clients, students or members in each age range: NA ___ 0-5 ___ 6-14 ___ 15-18 ___ 19-62 ___ 62-75 ___ 75-85 ___ 86+
2. Provide all applicable information:

Payroll: _____ Number of employees: _____ Number of volunteers: _____

Number of client workers: _____ Number of members: _____

3. Years under current management: _____
4. List all accreditations: _____

5. Is your organization a non-profit? YES NO

6. Is your organization or any location operated by you licensed by any regulatory authority? YES NO

If yes, a. Attach copies of all licenses and most recent inspection reports.

b. When were your facilities last inspected? _____

c. Were any violations or deficiencies noted on your most recent inspection? YES NO

7. Does your organization:
 - a. Provide adoption or foster placement services? YES NO
 - b. Provide methadone or detoxification services? YES NO
 - c. Provide services to sex offenders or those who have acted out sexually? YES NO
 - d. Provide services to bi-polar, schizophrenic, paranoid, psychotic or severely mentally ill clients? YES NO
 - e. Provide services to clients that are suicidal or violent? YES NO
 - f. Provide services to those with Alzheimer's or dementia? YES NO
 - g. Provide alternative sentencing, incarceration or lock-down programs? YES NO
 - h. Provide medical services (e.g. skilled nursing, medical treatment, etc.)? YES NO
 - i. Ever use chemical or physical restraints, or restraint techniques on clients or students? YES NO
 - j. Provide respite care? YES NO
 - k. Have employed doctors, dentists, psychiatrists or nurse practitioners? YES NO
 - l. Sponsor rallies, civil demonstrations or protests? YES NO
 - m. Own or operate tanning beds? YES NO
 - n. Provide commercial lending services or handle clients' money? YES NO
 - o. Only provide referrals to other organizations (no direct services)? YES NO

If yes to any listed above, describe: _____

8. Do you have any mentoring programs that match youth with mentors? YES NO

If yes, a. Is contact required to be in a group setting? YES NO

b. Provide a description of program and how many clients are served: _____

9. Does your organization provide services in private homes (e.g. meal delivery, chore assistance, respite care, etc.)? YES NO

If yes, provide a description of services and how many clients are served: _____

10. Do you accept donations of vehicles of any type? YES NO

If yes, how are vehicles used?

- a. Used in daily operations of organization Sold directly to the public as a fundraiser
- Vehicle is titled to an independent broker, when sold, profits are returned to the organization

b. How many vehicles do you receive in an average year? _____

11. Do you operate a bingo? YES NO
If yes, provide annual number of attendees: _____ and gross revenue: _____
12. What security measures are in place at your locations?
 Electronic locks on doors Alarmed doors Wander-guard Unarmed security guards
 Armed security guards Security cameras Other: _____
13. If armed security officers are indicated:
a. Officers are (indicate all that apply): Employed Contracted
b. Is insurance in place for the security force (either employed or contracted)? YES NO
If yes, attach a full copy of insurance policy.
14. Do you have any buildings that are more than 50% vacant or unoccupied? YES NO
15. Do you routinely receive donations of real property (land or buildings)? YES NO
If yes, describe type of property accepted, condition of property accepted and usage of property:

16. Do you have any plans for renovations or new construction during the next 2 yrs? YES NO
If yes, describe: _____
17. Are portable heaters used in any buildings? YES NO
If yes, describe type of heater and safety controls: _____
18. Do any locations have sprinklers? YES NO
If yes, are all sprinklers either recessed or protected by sprinkler head guards? YES NO
19. Does your organization provide accident insurance for members or clients? YES NO
If yes, a. Insurance company name: _____ Policy number: _____
Policy period: _____ Limits: _____
b. Accident insurance: applies to all members or clients is optional, at member or clients' expense

B. Organizations in Business Less than 3 Years SECTION NOT APPLICABLE

Complete this section if your organization has not been in business at least 3 years.

1. Please list all sources of funding or revenue and amount of funding or revenue for the current fiscal year:

2. What are total projected expenses for the current fiscal year? \$ _____
3. Attach copies of executive staff résumés.

C. Outdoor Playgrounds or Other Outdoor Property SECTION NOT APPLICABLE

Complete this section if your organization has any outdoor playgrounds or property.

1. Does your organization have outdoor play equipment at any location? YES NO
If yes, a. Was all equipment manufactured by a commercial manufacturer? YES NO
b. Was all equipment installed by an insured contractor? YES NO
2. Does your organization have any other type of outdoor property or equipment? YES NO
If yes, describe type of property or equipment, the location and the value below. If additional space is required, provide an attachment or list on the Acord Property application.

D. Facility Rental SECTION NOT APPLICABLE

Complete this section if your organization rents your premises to others.

1. Number of times a year your premises is rented, either for a fee or at no cost? _____
2. Are all renters required to sign written rental contract? YES NO
If yes, a. Does your rental agreement contain "hold harmless" clause in your favor? YES NO
b. Does your contract require you to be named as additional insured on the renter's policy? YES NO
c. Does agreement make the renter responsible for security during rental period? YES NO
3. Are all renters required to submit a certificate of insurance or a copy of the declarations page as proof of liability coverage? YES NO
4. Do you rent premises to those that do not carry liability insurance? YES NO

E. Media Exposures SECTION NOT APPLICABLE

Complete this section if your organization (check all applicable):

- Creates your own advertising, brochures, pamphlets, websites or other materials using photographs taken by you or someone in your organization.
 Sells music or printed materials created, published or produced by someone within your organization.
 Airs television, radio or internet broadcast segments, public service announcements (PSAs) or shows.

1. Do you always obtain written waivers that specifically release your organization from all liability arising from personal or advertising injury, prior to using the likeness of others (e.g. pictures) or prior to using the work product of others? YES NO
2. Frequency of broadcast segments: N/A Daily Weekly Monthly Infrequently
3. Describe all media created, produced or published by your organization: _____

4. Do you employ a contractor for creation or legal review of any materials? YES NO

If yes, describe materials subject to review and type of review: _____

5. Does your organization carry any type of media liability insurance (broadcasters' liability, publishers' liability etc.)? YES NO

If yes, attach a copy of the declarations page.

F. Abuse Sensitive Clients, Members, Students **SECTION NOT APPLICABLE**

Complete this section if your organization deals directly with minor clients (under age 18), developmentally or physically disabled clients, mentally ill clients or elderly.

1. As respects abuse,
 - a. Have any claims been filed or allegations of abuse been made against your organization or anyone working on behalf of your organization? YES NO
 - b. Are you aware of any occurrences that could lead to a claim? YES NO

If yes to above, explain: _____

2. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? YES NO
3. Does your organization require at least 2 employees or volunteers to be with clients at all times, prohibiting all employees and volunteers from being alone with clients? YES NO

If no, explain _____

4. Indicate all employee and volunteer screening controls used by your organization:

Provide the following information:

	EMPLOYEES	VOLUNTEERS
	<input type="checkbox"/> NO EMPLOYEES	<input type="checkbox"/> NO VOLUNTEERS
a. Written applications required	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Picture ID required	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal interviews conducted	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Personal references checked	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. At least 5 years of employment history verified	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Education of professionals verified	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Licensing/certification of professionals verified	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Explain any **NO** responses: _____

5. Indicate all background checks which are conducted:

Provide the following information:

	EMPLOYEES	VOLUNTEERS
	<input type="checkbox"/> NO EMPLOYEES	<input type="checkbox"/> NO VOLUNTEERS
a. No background checks conducted	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Name check – local level	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Name check – state level	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Name check – national level (e.g. using online vendor services)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State level 10-digit fingerprint check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. FBI fingerprint check regardless of time person has resided in the state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. FBI fingerprint check if person has resided in the state less than 5 consecutive years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

h. FBI fingerprint check – other criteria – describe: _____

i. Description of other screening methods: _____

6. Are all controls indicated in 4 and 5 above completed prior to:
 - a. Hiring employee or accepting volunteer? YES NO
 - b. Employee or volunteer contact with client? YES NO

Explain any **NO** responses: _____

7. Do applications contain a notice that a criminal background check may be run on all candidates? YES NO

If yes, does application advise applicant that they may be rejected or terminated based on an unacceptable background check? YES NO

8. How long are employee and volunteer records, including record of background checks, retained?

Number of years: _____ Permanently

G. Automobile Exposures**SECTION NOT APPLICABLE** *Complete this section if your organization has submitted owned, non-owned or hired automobile coverage to us.*

1. Does your organization own or lease autos? YES NO
2. Are all autos submitted for coverage titled to the organization? YES NO
If no, describe which autos are not titled to the organization and list the titled owner: _____
3. Do any autos have wheelchair lifts? YES NO
If yes, describe wheelchair lift training provided to drivers: _____
4. Do you provide transportation to any clients, members or the general public? YES NO
If yes, describe: _____
5. Does your organization spend more than \$2,500 on vehicle rentals per year? YES NO
If yes, annual cost: \$ _____
6. Do any employees or volunteers use their **personal automobiles** on behalf of the organization, either on a daily or weekly basis? YES NO
If yes, a. Number that have daily or weekly usage of **personal autos**: _____ employees _____ volunteers
b. Indicate type of usage:
 Errands
 Delivery of meals or property – average number of deliveries per week: _____
 Transportation of other people – average number of people transported per week: _____
c. Does your organization require proof of personal auto insurance on vehicles driven for your organization, at each policy renewal? YES NO
d. Does your organization have a minimum requirement for personal auto policy limits? YES NO
If yes, indicate minimum limits you require: _____
7. Does your organization run annual MVRs on:
a. Those who drive your autos? YES NO
b. Those who drive their personal autos on your behalf? YES NO

H. Sale or Distribution of Food or Merchandise**SECTION NOT APPLICABLE** *Complete this section if your organization sells food or merchandise or donates food or merchandise to others.*

1. Goods distributed or sold by the organization: Food New merchandise Used merchandise
2. Food is: Sold – Gross sales: \$ _____ Distributed to individuals – value distributed: \$ _____ pounds distributed: _____
 Distributed to other organizations – value distributed: \$ _____ pounds distributed: _____
3. Merchandise is: Sold – Gross sales: \$ _____ Distributed to individuals – value distributed: \$ _____
 Distributed to other organizations – value distributed: \$ _____
4. Goods arrive at your premises by Other organizations deliver Picked up in owned autos Picked up in personally owned autos
5. Goods are distributed by Picked up at your location by individuals/families Delivered in your owned auto
 Picked up by an organization Delivered in personally owned autos
6. Do you provide any warranties of quality or safety on any food or merchandise? YES NO
7. Do you refurbish, repair, repackage, re-label, remove labels or in any other way modify items (excluding cosmetic changes)? YES NO
8. Are all sales indicated to be “as is?” YES NO
If yes, this is indicated by: Signs Receipts Other: _____
9. Does the value of any item for sale exceed \$500? YES NO
If yes, describe items: _____
10. Are forklifts used? YES NO
If yes: a. Do forklifts have back-up alarms? YES NO b. Are forklift drivers certified to operate forklifts? YES NO
11. Do you publish and enforce housekeeping guidelines? **If yes**, attach copy of housekeeping rules. YES NO

I. Liquor or Alcohol Served or Sold**SECTION NOT APPLICABLE** *Complete this section if your organization sells alcohol, either annually or for special events.*

1. Gross annual alcohol sales: \$ _____
2. Is any employee or volunteer of your organization responsible for serving alcohol? YES NO
3. What alcohol dispensing controls are in place? _____
4. Type of license you have for sale of alcohol: Permit for event only Annual liquor license Alcohol served by caterer

J. Special Events

SECTION NOT APPLICABLE

Complete this section if your organization holds, sponsors or co-sponsors any special events or fundraisers.

- Total number of events: _____
- Complete chart below for each event. **If additional space is required, provide information on an attachment.**

Provide the following information:	EVENT 1	EVENT 2	EVENT 3
Name of event:			
Date, time and location of event:			
Total estimated attendance:			
Gross sales from admissions:	\$ _____	\$ _____	\$ _____
Gross sales from food or non-alcoholic beverage sales:	\$ _____	\$ _____	\$ _____
Gross sales from alcohol sales:	\$ _____	\$ _____	\$ _____
Other gross sales:	\$ _____	\$ _____	\$ _____
Annual event?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Has any claim or incident ever arisen out of this event?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Emergency medical personnel present?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Security personnel present?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Golf carts or trams at event?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Activities at event (use all applicable activity codes from list below):			

Activity Codes (for use above)

- | | | |
|---------------------------|--|---|
| A. Golf outing | H. Aircraft (motorized or not) | O. Parade (only entry of float into a parade) |
| B. Wine tasting | I. Animals | P. Parade – participation in a parade (no-floats) |
| C. Dinner, gala or picnic | J. Athletic participation | Q. Parade – sponsorship of a parade |
| D. Auction | K. Fireworks sales or show | R. Use of any motorized vehicle(s) |
| E. House tour | L. Haunted house or trail | S. Concert – describe type of music |
| F. Fashion or Art Show | M. Mechanical rides | T. Other – describe in space above |
| G. Bingo | N. Non-mechanical entertainment devices (e.g. bounce houses) | |

- Do you sponsor or co-sponsor any parades? YES NO
If yes, a. Number of: floats ____ horses ____ participants ____
 b. Do you require certificates of insurance, with \$1,000,000 liability limits from all participants? YES NO
- a. Describe all mechanical or non-mechanical devices used at special events: _____

 b. Are devices indicated provided and operated by a contractor? YES NO
If yes, do you obtain or require a certificate of insurance from the contractor? YES NO

K. Animal Rescue, Shelter, Humane Society or SPCA

SECTION NOT APPLICABLE

Complete this section if your organization provides animal shelter services.

- Indicate all of the following operations or services you provide:
 Gift Shop – gross sales: \$ _____ Pet Training – gross sales: \$ _____
 Pet Grooming – gross sales: \$ _____
- Number of kennels, cages or compartments on your premises: _____
- Does your organization provide shelter for large, wild or exotic animals? YES NO
- Total number of: a. Volunteer veterinarians: _____ b. Contracted veterinarians: _____ c. Employed veterinarians: _____
- What is the annual payroll for employed veterinarians? \$ _____
- Does your organization employ animal control officers? YES NO
If yes, a. Do the officers have arrest authority? YES NO
 b. Officers carry: Firearms/guns Tasers Tranquilizer weapons
 c. Does separate liability coverage apply to animal control officers? YES NO

- 7. Does your organization train all employees and volunteers in proper animal handling? YES NO
- 8. Does your organization test all animals for "adoptability" prior to adopting animals out? YES NO
- 9. Do you operate any mobile adoption vehicles? YES NO
- 10. Do you have a crematory? YES NO

L. Church or Religious Organization **SECTION NOT APPLICABLE**

Complete this section if your organization is a church or other religious organization.

- 1. Religious denomination: _____
- 2. Are any dwellings owned by your organization? YES NO
If yes, is housing provided for clergy only? YES NO
- 3. Does any building have either stained glass, statuary or other fine arts affixed to the building? YES NO
If yes, attach a schedule of fine arts with values for each item.

M. Performance Arts Operations **SECTION NOT APPLICABLE**

Complete this section if your organization offers performance arts (e.g. theatrical or musical productions).

- 1. What type of performances (e.g., ballet, plays, etc.)? _____
- 2. Total number of performances that occur annually: _____
- 3. What is the total annual attendance for all performances? _____
- 4. Do you hold any performances away from premises owned or leased by you? YES NO
If yes, do you provide ushers, ticket takers or ticket sellers? YES NO
- 5. Are any pyrotechnics used during performances? YES NO
If yes, describe type of pyrotechnics and safety controls in place: _____
- 6. Do you perform at locations owned by or leased to your organization? YES NO
If yes,

a. What is the seating capacity of the theater? _____	f. Are exits lighted? YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Is the building fully sprinklered? YES <input type="checkbox"/> NO <input type="checkbox"/>	g. Is there panic hardware on the exits? YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Are there curtains on the stage? YES <input type="checkbox"/> NO <input type="checkbox"/>	h. Is there balcony seating? YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes , are curtains fire resistant? YES <input type="checkbox"/> NO <input type="checkbox"/>	i. Is there a lowered pit area near the stage? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Are aisles lighted? YES <input type="checkbox"/> NO <input type="checkbox"/>	j. Do ushers assist patrons to seats during performances? YES <input type="checkbox"/> NO <input type="checkbox"/>
e. Is there emergency lighting? YES <input type="checkbox"/> NO <input type="checkbox"/>	

N. All Camps **SECTION NOT APPLICABLE**

Complete this section if your organization provides any camps (day camps or overnight).

- 1. Number of days the camp operates per year: _____ Average number of campers per day: _____
- 2. Number of campers in each age range: _____ under 12 _____ age 13–16 _____ over age 16
- 3. Total number of: _____ adult counselors _____ youth counselors

O. Camps With Campgrounds or Overnight Camping **SECTION NOT APPLICABLE**

Complete this section if your organization provides overnight camping or campgrounds.

- 1. What lifesaving skills are required of the counselors? CPR Lifeguard Training First Aid Other
- 2. Do you have a nurse on-site? YES NO
- 3. Do you keep a medical history on file for each camper? YES NO
- 4. Is the camp located in a canyon or an area prone to brush or wildfires? YES NO
- 5. Is camp located in a remote area? YES NO
If yes, describe all available sources of water and fire fighting equipment: _____
- 6. Does a caretaker live at the camp during the off-season? YES NO

P. Childcare, Headstart or Latchkey

SECTION NOT APPLICABLE

Complete this chart if your organization provides childcare, headstart or latchkey care.

LOCATION(S) (COPY THIS SHEET IF ADDITIONAL SPACE IF NEEDED)	NO. OF CHILDCARE PERSONNEL	AGE RANGE OF CHILDREN	NO. OF CHILDREN LICENSED FOR	AVERAGE DAILY ATTENDANCE FULL-DAY	AVERAGE DAILY ATTENDANCE HALF-DAY*

*Count each child as one attendee for Average Daily Attendance

Q. Schools

SECTION NOT APPLICABLE

Complete this section if your organization is a licensed school or other educational institution.

- Is this a charter school? YES NO
- Is corporal punishment coverage desired? YES NO
- Does school have any stadiums, bleachers or grandstands? YES NO
- Your school's primary purpose or mission is to provide the following types of education (check all applicable):
 - Art, dance or music Education to developmentally impaired Education to learning impaired Education to physically impaired
 - Education to emotionally impaired, including mentally ill, suicidal, violent and/or oppositionally defiant

R. Vocational training or sheltered workshops

SECTION NOT APPLICABLE

Complete this section if your organization provides vocational training or sheltered workshops.

- Number of: Supervisors/trainers: _____ Total clients per day: _____
- Number of: Physically disabled: _____ Mentally disabled: _____
- Number of job coaches you employ: _____ Payroll for job coaches: \$ _____
- Level of clients' disability – check all applicable: None Mild Moderate Severe/Profound
- Total annual sales from workshop: \$ _____ Annual sales from recycling: \$ _____
- Total annual payroll to clients: For janitorial services: \$ _____ For landscaping services: \$ _____
Total payroll to all clients: \$ _____
- Does your organization pay clients at least minimum wage for their work? YES NO
- Are all client workers covered under your workers compensation policy? YES NO
- If no**, are clients covered under any other organization's workers compensation? YES NO
- Do you perform component assembly or manufacturing for other companies? YES NO
- If yes**,
 - Are any components assembled or products manufactured for the auto, truck, aircraft or aerospace industry? YES NO
 - Attach a list of all companies and all products for each company.
 - Are written contracts in place for all work? YES NO
 - Do all contracts contain "hold harmless" clause in favor of your organization? YES NO
- Do you store or warehouse either product components or completed products? YES NO
- If yes**, list all storage locations and area on the GL ACORD application.
- Indicate all activities your clients participate in:

<input type="checkbox"/> Commercial cooking	<input type="checkbox"/> Laundry services or sewing	<input type="checkbox"/> Silk-screening or spray painting
<input type="checkbox"/> Construction trades (framing, roofing, etc.)	<input type="checkbox"/> Light office work, packaging or assembly	<input type="checkbox"/> Use of flammable or corrosive chemicals
<input type="checkbox"/> Electrical component wiring	<input type="checkbox"/> Recycling-processing	<input type="checkbox"/> Use of power tools or wood-working
<input type="checkbox"/> Heat sealing, shrink-wrapping	<input type="checkbox"/> Recycling-sorting only	<input type="checkbox"/> Use of scaffolding
<input type="checkbox"/> Janitorial or landscaping	<input type="checkbox"/> Repair of appliances or vehicles (cars, bikes, etc.)	<input type="checkbox"/> Welding
<input type="checkbox"/> Use of bailing machinery, conveyer systems, presses, press brakes or metal shearing machinery		
<input type="checkbox"/> Other: _____		
- Do you have a safety coordinator? YES NO
- Do you have an orientation program which all staff and regularly scheduled volunteers complete within their first month at the facility? YES NO
- If yes**, does orientation include:
 - A review of the facility's safety procedures? YES NO
 - Training in emergency procedures (including first aid)? YES NO
 - Job responsibilities? YES NO

S. Clubs – All Types**SECTION NOT APPLICABLE** *Complete this section if your organization is a club or membership based organization of any type.*

1. Does your organization own, lease, rent or use any buildings or locations? YES NO
- If yes,** a. What are the hours of operation each day? Mon-Thurs: _____ Fri: _____ Sat: _____ Sun: _____
- b. Are employees always on-site during operating hours? YES NO
- c. Are members allowed to access the facility during non-operating hours? YES NO
- d. Is club access restricted to club members and their guests? YES NO
- e. Are minors required to be accompanied by a parent or guardian? YES NO
- If no,** explain guidelines applicable to minors: _____
2. Indicate all applicable sources of income and gross sales from each:
- Membership or initiation fees: \$ _____ Food or beverage sales: \$ _____
- Other sales or income: \$ _____ Describe source of other sales or income: _____

T. Health or Exercise Clubs**SECTION NOT APPLICABLE** *Complete this section if your organization operates a health or exercise club.*

1. Has your facility or part of your facility been inspected by any regulatory or health authority within the past five years? YES NO
- If yes, attach a copy of your most recent inspection.**
- a. Were any violations or deficiencies found in your most recent inspection? YES NO
- b. How often are you subject to inspection and by what authority? _____
2. How often do you inspect your premises and equipment? _____
3. Do you maintain an inspection log to document inspections? YES NO
4. Are signs posted throughout the facility indicating how to properly use the equipment? YES NO
5. Are ground fault interrupters (GFI) used on all outlets in all wet areas (e.g. showers)? YES NO
6. Are all wet areas (e.g. showers, locker rooms, etc.) equipped with slip resistant flooring? YES NO
7. Do you require at least one CPR and First Aid certified employee to be on duty at all times? YES NO
8. Are there written medical emergency and evacuation procedures in place? YES NO
- If yes,** are all employees and contractors trained in emergency procedures? YES NO
9. Are incident reports completed and maintained for all injuries, regardless of severity? YES NO
10. Indicate all services or programs offered:
- Babysitting (while parent(s) exercise) Body wrapping Nutritional counseling Weight loss competition(s)
- Beauty salon/hair services Diet center/weight loss Physicals/stress testing
- Blood analysis Massage Sports medicine/rehab
11. Do you sell any dietary supplements or herbal remedies? YES NO
- If yes,** do you manufacture or re-label any products as your own? YES NO
12. Do you employ any certified athletic trainers? YES NO
- If yes,** please describe daily activities of CAT: _____
13. Do you offer any services where there are not at least two staff members present? YES NO
- If yes,** describe services: _____
14. Do you run criminal background checks on employees? YES NO

U. Athletic Activities**SECTION NOT APPLICABLE** *Complete this section if your organization provides any athletic activities.*

1. Is a waiver required to be signed by participant, the parent or guardian of the participant prior to participation in all athletic activities? YES NO
- If yes,** has your waiver form been reviewed by legal counsel? **Attach** copy of waiver. YES NO
2. Indicate all of the following activities that you offer at any location:
- | | | |
|--|--|--|
| <input type="checkbox"/> Acupuncture/acupressure | <input type="checkbox"/> Football – tackle | <input type="checkbox"/> Rollerblading, skating, skateboarding |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Free weights | <input type="checkbox"/> Scuba classes or training |
| <input type="checkbox"/> Aerobic boxing/kick-boxing | <input type="checkbox"/> Hockey - ice, street, roller or field | <input type="checkbox"/> Skiing (downhill) or snowboarding |
| <input type="checkbox"/> Archery | <input type="checkbox"/> Inflatable devices, eg. bounces | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Baseball/softball/basketball/soccer | <input type="checkbox"/> Lacrosse/rugby | <input type="checkbox"/> Trampolines, mini-trampolines |
| <input type="checkbox"/> Biking, mountain biking, BMX dirt bikes, etc. | <input type="checkbox"/> Obstacle course(s) | <input type="checkbox"/> Use of motorized vehicles, such as ATV, motorcycles |
| <input type="checkbox"/> Boxing/Kickboxing – Contact | <input type="checkbox"/> Outdoor rock climbing, rappelling | <input type="checkbox"/> Water skiing or kayaking |
| <input type="checkbox"/> Circuit training/cardio | <input type="checkbox"/> Paintball | <input type="checkbox"/> Wilderness trips |
| <input type="checkbox"/> Diving | <input type="checkbox"/> Racquetball or squash | |
| <input type="checkbox"/> Football – flag | <input type="checkbox"/> Rifery | |
- Describe in detail each activity indicated and safety controls in place: _____
3. Do you organize any or offer league or team sports? YES NO
- If yes,** total number of registrants and description of sports: _____
4. Do you sponsor competitions or teams that participate in competitions? YES NO
- If yes,** describe: _____

5. Do you offer martial arts programs? YES NO
If yes, a. Martial arts are (check all applicable): Non-contact Partial contact Full contact
b. Are any bladed weapons ever used? YES NO
c. Describe specific types of martial arts offered and safety equipment required: _____

6. Do you offer gymnastics programs? YES NO
If yes, a. Describe your gymnastics program, including levels, type of equipment used, number of registered participants:

- b. Describe the mats and crash pads around all equipment and how they are secured in place:

7. Do you offer skateboarding or own or operate a skate park? YES NO
If yes, a. Describe your skateboarding program and activities, including facility and number of registered participants. Include photos of the skateboarding area.

- b. Is the skateboard facility supervised by your adult employees or volunteers? YES NO
c. Are all skateboarders required to wear helmets, wrist guards, elbow pads, knee pads, appropriate shoes and clothing? YES NO
8. Do you offer whitewater boating or rafting activities? YES NO
If yes, a. Describe whitewater activities including river rating scale or class and number and ages of registrants:

- b. Are all boats staffed by an experienced, insured guide? YES NO
c. Do you require at least one member of the trip to be skilled in life saving techniques? YES NO
d. Are all rafters required to wear a helmet and life vest with leg straps? YES NO
e. Are all rafters trained on safety procedures? YES NO
9. Do you offer other boating activities? YES NO
If yes, a. Number of boats you own or operate? ____ boats without motors ____ motorboats
b. Are all boaters and skiers required to wear life vests with leg straps? YES NO
10. Do you offer snow skiing or snowboarding? YES NO
If yes, a. Describe your skiing and snowboarding activities, including styles, age and number of participants and number of instructors: _____
b. Are all ski activities conducted at a commercially operated ski facility? YES NO
c. Are all skiers required to wear helmets and goggles? YES NO
11. Do you offer horseback riding activities of any kind? YES NO
If yes, a. Describe riding activities including locations where riding is done, type of riding, and number of participants registered:

- b. Is jumping or racing prohibited? YES NO
c. Is riding restricted to an arena or enclosed area? YES NO
d. Are all riders required to wear riding helmets, appropriate clothing, and shoes? YES NO
e. Number of horses owned by your organization? _____
f. Are all riding activities provided by independent contractors? YES NO
12. Do you own or operate any rope courses? YES NO
If yes, a. Describe the course and program, including location, number of elements, height, frequency of use, and number of users annually. Include photos of your rope course. _____
b. Describe the qualifications and training program of your course operators or supervisors:

- c. Describe safety controls in place: _____
d. Are all participants required to wear a helmet? YES NO
e. Is all safety equipment inspected prior to every use? YES NO
f. Was course designed, built, and inspected by an ACCT Professional Vendor Member? YES NO
13. Do you own or operate a climbing wall or tower? YES NO
If yes, a. Climbing wall or tower is: Located inside a building Located outside
b. Was the wall or tower designed and installed by a licensed, insured contractor? YES NO
c. Indicate climbing styles available: Bouldering (maximum height: _____) Top-rope Lead climbing
d. Are climbers permitted to climb without harness, helmet or other safety equipment? YES NO
If yes, describe under what circumstances: _____
e. Describe your methods of screening users before allowing them to climb or belay:

- f. Are belay system anchors "backed-up"? YES NO

- g. Is the belayer anchored to a secure point? YES NO
- h. What is the minimum age for belayers? _____
- i. Is there a minimum of 6 inches of fall protection beneath the climbing wall or tower out to a distance of 6 feet from the base of the wall(s)? YES NO
- j. Are rules, regulations and emergency procedures clearly posted in the climbing area? YES NO
- k. Describe wall & equipment inspection and maintenance procedures & schedule, including how records are maintained:

- l. Is there a program in place to identify equipment that needs to be replaced? YES NO
- m. How do you control access to the climbing wall or climbing area, both during and after business hours?

- n. Are the following always present when the wall is being used:
1. A staff member who is trained in the safety rules and is certified to belay? YES NO
 2. A full-time staff member who is certified to provide first aid? YES NO
 3. A first aid kit? YES NO
- o. Describe your emergency response plan in case of an accident: _____

- p. Number of climbers or belayers that have been injured in the past year? _____
14. Do you own or operate any swimming pools? YES NO

- If yes,** a. Number of pools on your premises: _____
- b. Provide information on all pools below. If more than 3 pools, please provide information on an attachment.

	POOL 1	POOL 2	POOL 3
Size, location and description:	_____	_____	_____
Indicate number of drains:	_____	_____	_____
Indicate shallow-end depth:	_____	_____	_____
Indicate deep-end depth:	_____	_____	_____
How is depth marked (e.g. painted markers on pool bottom, life line)?	_____	_____	_____
Describe any diving boards, diving platforms, slides or water trampolines:	_____	_____	_____
Indoor?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Enclosed by "child proof" gate?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Slip resistant surfacing?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Pool chemicals kept in a dry, ventilated, locked storage area?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Does pool have a pump safety shutoff?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Always a certified lifeguard on duty?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Safety equipment easily accessible within the pool area (i.e. hooks, life preservers, kick boards)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Phone in the pool area with emergency phone numbers posted nearby?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Suspended ceilings above pool?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

15. Do you have any water park playground areas? YES NO
- If yes,** describe surfacing and playground elements: _____
16. Do you own or operate any hot tubs or whirlpools? YES NO
- If yes,** a. Do all hot tubs or whirlpools have at least 2 drains? YES NO
- b. Is there a clearly marked emergency pump shutoff switch nearby? YES NO
- c. Are temperatures always kept at 104° or less? YES NO
- d. Is the hot tub operated on an automatic timer? YES NO
- e. Are unsupervised minors prohibited? YES NO
17. Have all pools and spas been equipped with anti-entrapment drain covers or systems? YES NO
- If yes,** describe systems installed and date for each pool or spa: _____

V. Residential or Overnight Housing – All Types

SECTION NOT APPLICABLE

Complete this section if your organization provides overnight housing of any type.

1. Is property subject to HUD inspection? YES NO
If yes, attach copy of REAC report.
2. Is smoking permitted inside any location? YES NO
3. Are all units equipped with smoke detectors? YES NO
If yes, indicate all that apply: hardwired battery operated hardwired with battery backup
4. Do you have any locations with sleeping areas above the second floor? YES NO
If yes, are all such buildings 100% sprinklered (including sleeping areas)? YES NO
5. Are all units equipped with carbon monoxide detectors? YES NO
6. Do you allow grills or fire-pits on patios or balconies? YES NO

W. Residential other than Apartments

SECTION NOT APPLICABLE

Complete this section if your organization provides residential or overnight facilities, other than apartments.

1. What is your staff to client ratio? _____
2. Are male and female residents separated unless they are part of the same family? YES NO
3. Type of clients or residents in your care overnight – complete chart:

TYPE OF CLIENTS	NO. OF CLIENTS	TYPE OF CLIENTS	NO. OF CLIENTS
Assisted living– seniors or developmentally disabled	_____	Respite care	_____
Half-way house or transitional housing	_____	Shelter – homeless or battered families	_____
Hospice	_____	Shelter – victims of sexual abuse	_____
Independent living – seniors or developmentally disabled	_____	Skilled care	_____
Inpatient crisis center	_____	Sober living (post detox)	_____
Residential therapeutic treatment	_____	Other (specify) _____	_____

4. Are any residents mentally ill or mentally disordered? YES NO

If yes, complete chart:

DISORDER	TOTAL PERCENTAGE OF RESIDENTS WITH DISORDER
<input type="checkbox"/> Autism or related disorders	_____ %
<input type="checkbox"/> Cognitive disorders: e.g. delirium, dementia, Alzheimers, or memory problems	_____ %
<input type="checkbox"/> Conduct disorders: e.g. vandalism, aggression, truancy, problems with impulse control	_____ %
<input type="checkbox"/> Eating disorders: bulimia, anorexia	_____ %
<input type="checkbox"/> Mood disorders: e.g. bi-polar, mania, manic depressive, depression	_____ %
<input type="checkbox"/> Psychotic disorders: e.g. schizophrenia or schizoaffective disorder, paranoia	_____ %
<input type="checkbox"/> Pyromania or fire-starting	_____ %
<input type="checkbox"/> Sexual acting out or pedophilia	_____ %
<input type="checkbox"/> Suicidal or self-injurious	_____ %
<input type="checkbox"/> Other – describe: _____	_____ %

5. Number of residents that have eloped, disappeared or gone absent without permission from any of your facilities during the current year and prior two years: _____
6. Do you prohibit acceptance of residents who have been convicted of a violent or sexual crime? YES NO
7. Does your organization provide assistance with activities of daily living (ADL)? YES NO

If yes, total number of clients: _____

- a. Number of non-ambulatory residents at each location (residents that cannot walk or move without the assistance of a wheelchair, walker or cane): Location 1: _____ Location 2: _____ Location 3: _____
 Additional locations: _____
- b. Indicate number of clients' by level of functionality in each ADL in the chart below:

ADL – ACTIVITIES OF DAILY LIVING	NUMBER OF CLIENTS THAT PERFORM WITH NO PHYSICAL ASSISTANCE	NUMBER OF CLIENTS THAT PERFORM WITH MINIMAL PHYSICAL ASSISTANCE	NUMBER OF CLIENTS UNABLE TO PERFORM WITHOUT ASSISTANCE
Bathing (sponge, bath or shower)	_____	_____	_____
Dressing	_____	_____	_____
Toileting	_____	_____	_____
Transferring (in/out of bed or chair)	_____	_____	_____
Assisting with incontinence	_____	_____	_____
Eating	_____	_____	_____

X. Professional Liability

SECTION NOT APPLICABLE

Complete this section if your organization would like a quote for professional liability.

1. Does your organization provide:
 - a. Alternative or complementary medical practices (e.g. acupuncture, chiropractic, herbal remedies, hypnotherapy, healing services, etc.)? YES NO
 - b. Catheterization, feeding tube maintenance or injection of prescribed medications? YES NO
 - c. Obstetrical/gynecological services? YES NO
 - d. Prescription of medications? YES NO
 - e. Advocacy (representation of individuals in legal proceedings) or legal services? YES NO
 - f. Crisis intervention (hotline, inpatient, etc.)? YES NO
 - g. Counseling for those with eating disorders? YES NO
 - h. One-on-one or peer counseling? YES NO
 - i. Program for individuals with infectious or contagious disease? YES NO

If yes to any above, provide detailed description of services: _____

2. Indicate if any of the following types of professionals work for your organization. **If your organization employs professionals in these positions, contact your agent before proceeding:**

NAME OF POSITION	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Medical Doctor, Dentist, Psychiatrist	_____	_____	_____
Nurse Practitioner, Physician Assistant	_____	_____	_____
Medical Students	_____	_____	_____

3. List number of employees (full or part-time), volunteers and contractors by position: Check if organization has no degreed professionals.

NAME OF POSITION	EMPLOYEES	VOLUNTEERS	CONTRACTORS
Clergy	_____	_____	_____
Health care professionals (e.g. CNA, LPN, RN, speech therapists, occupational therapists, etc.)	_____	_____	_____
Teachers, daycare workers	_____	_____	_____
Special education teachers, guidance counselors, vocational counselors	_____	_____	_____
Mental health professionals (e.g. psychologists, social workers, counselors)	_____	_____	_____
Student interns under your supervision	_____	_____	_____
Other degreed professionals (Describe degree level and position):	_____	_____	_____
TOTAL NUMBER:	_____	_____	_____

4. Of the employees, volunteers and contractors listed above, do any carry their own professional liability insurance? YES NO
If yes, are procedures in place to verify current insurance is maintained at all times? YES NO
5. Do you maintain copies of licenses for all employed, volunteer and contracted professionals who are required to be licensed? YES NO
If yes, are procedures in place to verify current licenses are maintained? YES NO
6. Does your current insurance program provide professional liability coverage? YES NO
If yes, is your policy claims made? UNKNOWN YES NO
7. Has any organization employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES NO
8. Has your organization's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES NO
9. Have there been any allegations of negligence or failure to comply with any regulatory or licensing guidelines within the past 5 years? YES NO
10. **As respects professional liability coverage**, is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy? YES NO

Completed by: _____ Date Completed: _____