

EMPLOYER ASSESSMENT TOOL

Company Name _____

E-mail _____

Contact Name _____

Phone _____

Your Workforce at a Glance

1. Primary Industry _____

2. What job types make up your current work force?
 (Check all that apply)

- a. Manual labor
- b. Office work-computer/seated
- c. Skilled labor. List specific specialties:

3. Number of employees _____

4. Do any of your staff fall under DOT guidelines?

- a. Yes. If yes, how many _____
- b. No

5. Please list your top three health and safety concerns for your organization.

- a. _____
- b. _____
- c. _____

6. Please list the top three injuries or reasons for lost time with your work force.

- a. _____
- b. _____
- c. _____

7. In your organization, what factors contribute to rising healthcare costs? _____

8. What health insurance does the company offer to employees? _____

9. Check any of the programs that are currently in place at your organization:

- Free flu vaccination
- Drug screening prior to employment
- Random drug and alcohol screening
- Hearing screening
- Eyesight screening
- Ergonomic assessment

10. Do you have an employee wellness program?

- No
- Yes:
 - a. Is it run internally or by an outside group?

 - b. Is participation connected with any incentives (i.e. health insurance discounts, prizes)? Please describe (program overview and incentive)

11. When do you plan to implement new employee health services? (timeline) _____

Complete this form. Save to your computer, then email to us at occupationalhealth@uplandhillshealth.org

