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COVID-19 INFECTION CONTROL PROTOCOL SURVEY

*This survey is for use with the following:
 Camps, Conference Centers, and Retreat Centers,
 Nonprofit and Human Service Organizations, Schools, Colleges, and Universities.*

Date: _____ Account Number: _____

Named Insured: _____

Clients	Response
<i>The term "clients" may include any of the following: Clients, Residents, Campers, Students, Customers, Patrons, or Members.</i>	
1. Are you aware of and following the latest CDC guidance for prevention of transmission?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
2. Have you implemented social-distancing policies at each of your premises and have all staff been trained on the new rules?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
3. If a client shows signs of a respiratory infection, does your organization report this to the state and local health department immediately and seek their guidance on how to respond?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
4. Does your organization isolate suspected COVID-19 clients? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
5. Does your organization test suspected COVID-19 clients? If yes, what is the turnaround time?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
6. Do you permit clients with a confirmed diagnosis of COVID-19 to continue to stay on premises, continue to live on premises (if you offer housing), or continue to participate in your programs and services?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

7. If you answered "yes" to the question 6 above, do you isolate clients with confirmed COVID-19 into a separate section of the premises and prevent clients from other areas of the premises from accessing the area?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. Will you admit a new client onto your premises with a known or suspected COVID-19 diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9. Do you require your clients to sign a waiver that releases you from liability associated with COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
10. For organizations operating overnight or residential facility only:		
<ul style="list-style-type: none"> ● Are residents permitted to leave the premises and then return? If yes, what procedures are followed upon their return? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<ul style="list-style-type: none"> ● For residents on site with suspected or confirmed COVID-19, do you require that they remain in their rooms with their room doors closed? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Staff	Response	
1. Do you have a designated infection control prevention specialist employee/volunteer at each of your Locations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. Are all employees/volunteers screened in advance with the following questions:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<ul style="list-style-type: none"> ● Have they traveled in the last 14 days? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<ul style="list-style-type: none"> ● Have they had any of the following symptoms in the last 14 days: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<ul style="list-style-type: none"> ● Have they had any known contact in the last 14 days with someone infected by or suspected to be infected by COVID-19? (Or presenting the above symptoms?) 	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

3. If they answer yes, to any of the questions above in question 2, are they instructed not to come to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. Are the responses to the question number 2 above, from employees/volunteers, documented in writing, and retained in case needed as future proof?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Have all employees/volunteers been trained on the above screening process, plus hand hygiene, and cleaning and disinfection protocols for environmental surfaces?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Does the organization test suspected COVID-19 employees/volunteers? If yes, what is the turnaround time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. Are all employees/volunteers required to wear masks What type of mask is required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. For employees/volunteers required to wear masks, are all of them trained on proper fitting/usage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9. If an employee/volunteer develops symptoms of a respiratory infection while working, are they instructed to stop working, put on a face mask, and self-isolate at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
10. Does the organization have a contingency plan in place in the event of staffing shortages related to staff being sent home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Visitors	Response	
Visitors means anyone who comes to your premises that is not an employee, volunteer, or client (see broad definition above). Visitors may include vendors, parents/guardians of clients on your premises, visitors of clients on your premises, etc.		
1. Are visitors permitted to enter your premises? If no, skip this section.	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

2. Are all visitors to your organization screened in advance of entry with the following questions:

- Have they traveled in the last 14 days? Yes No _____
- Have they had any of the following symptoms in the last 14 days: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea? Yes No _____
- Have they had any known contact in the last 14 days with someone infected by or suspected to be infected by COVID-19 (or presenting the above symptoms)? Yes No _____
- If you elect to admit a visitor that has a concerning answer to any of the above questions, does admission require sign-off by management? Yes No _____

3. For organizations operating overnight or residential facility only:

- If you are doing such visitor screenings, are the responses documented in writing and retained in case needed as future proof? Yes No _____

4. Are visitors required to wear a mask? Yes No _____

5. Do you require your visitors to sign a waiver that releases you from liability associated with COVID-19? Yes No _____

Environment	Response
1. Is personal protective equipment accessible to all staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
2. Do you have a steady and reliable source for your personal protective equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
3. Are work and commons areas being cleaned and disinfected regularly? If yes, how often?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

4. Are adequate supplies of disinfectants on hand at present?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Does the organization keep written documentation of environmental controls being employed, including the date these controls were implemented/completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Has the organization reviewed the CDC recommendations for infection control and "frequently asked questions" on infection prevention and control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. Does your organization have signage for infection prevention with reminders of hand hygiene, cough etiquette, and mask attire?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

I, the undersigned, attest that I have direct knowledge of the topics being asked about above in my organization and that the answers provided in this survey are true and accurate to the best of my knowledge as of the date shown below.

Note: If multiple premises or subsidiaries for this insured (or potential insured) are being insured by (or being submitted to Church Mutual for consideration of coverage), it will be assumed that the answers provided herein are universally applicable across all those premises or subsidiaries. If that is not the case, you must:

- a) Submit separate surveys for each (including the address for each in the comments section); or
- b) Explain any differences in answers by premises or subsidiary in the comments section below; or
- c) Attach documentation hereto that explains the differences in answers.

Named Insured Organization (First Named Insured): _____

Written name of the person completing this survey: _____

Signature of the person completing this survey: _____

Title of the person completing this survey: _____

Date: _____

Comments: _____