

## **Instructions for Implementing the Wellness/Fitness Leader Application in your MN State Agency**

The attached **Wellness/Fitness Leader Application** is provided by Work Well, the health improvement benefit provided for all State of Minnesota employees.

It is provided as a template for Minnesota state agencies who may wish to use it as is, or modify it to fit the needs and guidelines of their agency.

Please direct comments and questions to:

Worksite Wellness  
Minnesota Management & Budget  
400 Centennial Building  
658 Cedar St.  
St. Paul, MN 55155

[Work.Well@state.mn.us](mailto:Work.Well@state.mn.us)  
651-355-0100

Dear Wellness/Fitness Leader,

Carefully complete the attached materials, for our information and for yours. You may wish to bring it with you on a pre-class site tour. Much of the emergency information can be gathered on that tour and from your state agency contact.

An important note: we recommend (and some state agencies will require) that you carry adequate personal liability insurance before you begin leading this class. The State of Minnesota provides space for your class but cannot be held liable for any damage or injury arising from the use of the space for employee fitness and wellness classes (Section 1. Minnesota Statutes 2008, section 16B.24 Subd. 5b). This statute does not protect an instructor, paid or unpaid, in the event of damage or injury.

Please give a copy of this completed form to your state agency contact, and keep a copy for your information.

Thank you for offering your skills to State of Minnesota employees.

Sincerely,

# Wellness/Fitness Leader Application

Date:

## Leader Contact Information

First Name		Last Name	
Work Address			
City		State	Zip
Home Address			
City		State	Zip
Phone (1) ( )		Phone (2) ( )	
Email Address			

## Course Information

Course Name	
Course Location	
Begin Date	End Date

## State Agency Contact Information

Agency Name		
Contact Person Name		
Address		
City		State Zip
Phone ( )	Email Address	

## Leader Qualifications

1. Do you have current CPR certification or training? (Recommended) <input type="checkbox"/> Yes (copy of certificate provided) <input type="checkbox"/> No
2. Do you carry personal liability insurance? (Recommended) <input type="checkbox"/> Yes (copy of certificate provided) <input type="checkbox"/> No

**Previous Experience**

Name of Course	
Location	Month/Year Taught
Reference Name	Reference Telephone ( )

Name of Course	
Location	Month/Year Taught
Reference Name	Reference Telephone ( )

Name of Course	
Location	Month/Year Taught
Reference Name	Reference Telephone ( )

**Signatures**

Leader Signature	Date
State Agency Contact Signature	Date

Please send completed and signed application to state agency contact listed above.
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**\*\*\* Complete and Bring the Information Below With You to Each Class \*\*\***

**Emergency Procedures**

Emergency situations arise at any time. Expedient action must be taken in order to provide the best possible care to participants in emergency and/or life threatening conditions. The development and implementation of an emergency plan will help ensure that this care is provided.

Work with your agency contact to complete this form. Familiarize yourself with these emergency procedures and bring these pages with you each time you lead class.

**Before Each Class**

1. Record the following information:
  - a. name of building \_\_\_\_\_
  - b. address \_\_\_\_\_
  - c. room and floor number in which you will lead class \_\_\_\_\_
  - d. evacuation route from the room \_\_\_\_\_
  - e. locate the nearest phone \_\_\_\_\_
  - f. locate the nearest automated external defibrillator (AED), if one is available \_\_\_\_\_
2. Ask for a volunteer room assistant (optional). This person might help with participant sign-ins, room arrangement, lights, music, etc.
3. Require that each participant sign the "Wellness Class Attendance/User Agreement, Release and Waiver of Liability" form (attendance form) provided by your Agency Contact. Provide a copy of the signed waiver to participants at the next class.
4. This attendance form will be signed by each participant at the start of each class, but need not be copied and returned each time.
5. Inspect all equipment that will be used in the class to determine if the equipment is in safe operating condition. When repairs are necessary, see that the equipment is taken out of operation and properly repaired.
6. When equipment is used, be sure that each participant receives basic instruction on its use.
7. Understand the building procedure in case of a weather emergency.

**In the Event of an Accident or Injury**

1. Have yourself or another individual remain with the injured party. Have yourself or another calm individual call 911. The caller will need to have the address and location of the injured party.
2. Assign someone to meet the emergency responders.
3. Have someone remain with the injured party while you or another individual retrieves any necessary emergency equipment.
4. The most qualified individual on the scene should provide acute care in an emergency situation. Ask participants and assess who is qualified. It may or may not be you.
5. Be sure other class participants are safe, or have them move to safety.
6. Within a day of the emergency, contact the injured party or his/her emergency contact. The purpose of this call is to express concern and inquire about his/her status and recovery.
7. Within a day of the emergency, complete and sign the attached incident report.
8. Evaluate all procedures involving the incident to discover if changes should be made to these procedures. Recommend changes.

## Report of Accident or Injury

Please complete this report in the case of accident or injury while you are leading a State of Minnesota employee wellness program.

Name of State Agency	
Your Name	
Phone (     )	Email Address

Date of Accident or Injury	Time of Incident (include a.m. or p.m.)
Description of Incident (how, where, and why)	
Extent of Injury to Person(s)	
Injured Person(s) Name, Address and Phone Number	
Witnesses' Names, Addresses and Phone Numbers	
Additional Comments	

Signature	Date
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Please give completed report to your agency contact.

Agency contact, please send a copy of this completed report to:

### **Worksite Wellness**

Minnesota Management & Budget  
400 Centennial Building  
658 Cedar St.  
St. Paul, MN 55155  
[Work.Well@state.mn.us](mailto:Work.Well@state.mn.us)