**Subcontractor Safety Pre-qualification Form**

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Completing Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Company Designated Safety Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number for Company Designated Safety Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **List your Firm’s Experience Modification Rate (EMR) for the three most recent years.**

20\_\_\_ EMR: \_\_\_\_\_\_\_\_\_\_\_

20\_\_\_ EMR: \_\_\_\_\_\_\_\_\_\_\_

20\_\_\_ EMR: \_\_\_\_\_\_\_\_\_\_\_

1. **Please provide the following data for the past three completed years (Use your OSHA 300 and OSHA 300A Log to complete this section):**

|  |  |  |  |
| --- | --- | --- | --- |
| Number of Injuries and Illnesses Cases: | 20\_\_\_ | 20\_\_\_ | 20\_\_\_ |
| a. Total # of Fatalities Cases (Column G): | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |
| b. Total # of Days Away from Work Cases (Column H): | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |
| c. Total # of Job Transfer/Restricted Cases (Column I): | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |
| d. Total # of other Recordable cases (Column J): | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |
| e. Total # of cases for a, b, c, and d (above) | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |
| f. Total # of employee hours worked: | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |

**3. Safety Information**

|  |  |  |
| --- | --- | --- |
| Does your company have a written safety program? | YES\_\_\_\_ | NO\_\_\_\_ |
| Does the safety program contain a: |  |  |
| Hazard Communication Policy? | YES\_\_\_\_ | NO\_\_\_\_ |
| Fall Protection Policy? | YES\_\_\_\_ | NO\_\_\_\_ |
| PPE Policy? | YES\_\_\_\_ | NO\_\_\_\_ |
| Does your company have a mandatory substance abuse program? | YES\_\_\_\_ | NO\_\_\_\_ |
| Do all new employees complete safety orientation? | YES\_\_\_\_ | NO\_\_\_\_ |
| Does your company conduct jobsite safety inspections? | YES\_\_\_\_ | NO\_\_\_\_ |
| Does your company require the OSHA 10-Hour for all supervisors? | YES\_\_\_\_ | NO\_\_\_\_ |
| Does your company conduct documented post-accident investigations? | YES\_\_\_\_ | NO\_\_\_\_ |
| Does your company ensure each project is supervised by a competent person? | YES\_\_\_\_ | NO\_\_\_\_ |
| Has your company had any OSHA citations, violations or fines within the last 3 years? If yes, please explain:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_  Signature Date | YES\_\_\_\_ | NO\_\_\_\_ |