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| Contractor Pre-Qualification Safety Questionnaire |

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| Date:       |  |
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| Client Name:       Information required in this document will be provided to the above named client. Client will review and make all determinations regarding acceptability based on initial and follow up information requested and provided. |

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| --- | --- |
| Company Name |       |
| Address |       |
| City |       |
| State |       |
| Zip Code |       |
|  |  |
| SIC Code |       |
|  |  |
| Corp. Safety Director |       |

|  |  |
| --- | --- |
| Phone Number |       |
| Email |       |
|  |  |
|  |  |
|  |  |
|  |  |
| Years in Business |       |
|  |  |
| Phone Number |       |
| Email |       |

**Company Background (*Explain the type of work your Company performs*):**

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|       |

Section A – Experience Modification Rate (EMR)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please obtain from your insurance agent/broker/carrier, Company’s EMR for the last three (3) rating periods. Contractor may be considered ineligible if current year or most recent three-year average EMR is above the identified threshold.

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| **Experience Modification rate (EMR) Threshold:**       |
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| **Current Year EMR:**       | **Policy Year:**       |
| **Previous Year 1:**       | **Policy Year:**       |
| **Previous Year 2:**       | **Policy Year:**       |
| **Previous Year 3:**       | **Policy Year:**       |

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| If Contractor’s current EMR, or average EMR over the most recent three (3) year period is above the Identified threshold, the following information must be provided:1. Written explanation of why contractor’s EMR is above the threshold;
2. Written outline of corrective actions currently being undertaken to reduce injuries, illnesses and

 workers compensation losses by the contractor;1. Copy of Contractor’s Corporate Safety and Health Program
2. Name and qualification of individual(s) responsible managing and overseeing this initiative;
3. Copy of Contractor’s Worker’s Compensation Loss Runs for the past 3 years

Determinations made arebased on the above information provided, as long as contractor has satisfied therequirements of Section A, even if its current or three-year average EMR is above the identified threshold. |
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Section B – OSHA Incident Rates

Evaluation of the Contractor’s OSHA Recordable and Loss Time Incident Rate compared to the most current data provided by the Annual Survey of Occupational Injuries and Illness conducted by the Bureau of Labor Statistics, U.S. Department of Labor (BLS). The Contractor’s most recent three-year (3) period will be evaluated.

Contractor may be considered ineligible if Total Recordable or Loss Time Incident Rate average for the most recent three-year (3) period exceed the applicable statistical standards for its business category.

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| **Industry Comparison Information** |

**Provide your North American Industry Classification System (NAICS) Code:**

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Information to assist in completing Section B. Click on each table above to open sheet and input information.

**OSHA Recordable Incident Rate =** Total # of Recordable Cases x 200,000

 Divided by Company Man-hours

**OSHA Loss Time Incident Rate =** Total # of Loss Time Cases x 200,000

 Divided by Company Man-hours

If Contractor’s average total recordable or loss time incident rate compared to the most recent three-year (3) period exceed the applicable statistical standards for its business category, the contractor must submit the following:

1. Written explanation why Contractor’s Incident Rate exceeds the BLS Incident Rate
2. Written outline of corrective actions currently being undertaken to reduce employee injuries

 and illnesses;

1. Copy of contractors Corporate Safety and Health Program
2. Copy of Contractors OSHA 300 log for each of the past three (3) years

Determinations made are based on the above information provided, if the contractor has satisfied the requirements of Section B even through it has an Incident Rate that exceeds the BLS Incidence Rate.

Section C – OSHA History

Contractor’s OSHA inspection history with respect to Serious, Repeat and Willful citations during the past five (5) year period will be evaluated.

Has Contractor received any Serious, Repeat or Willful Citations within the past five years, beginning immediately prior to the submittal of this questionnaire; this includes contested citations that have not yet been resolved.

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| YES       | NO       |

If yes, list total number of citations by type per year in the chart below. Submit copies of all citations and explanation of abatement actions taken.

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| --- | --- | --- | --- | --- | --- |
| Year       | Serious       | Repeat       | Willful       | Fatality       | Total       |
| Year       | Serious       | Repeat       | Willful       | Fatality       | Total       |
| Year       | Serious       | Repeat       | Willful       | Fatality       | Total       |
| Year       | Serious       | Repeat       | Willful       | Fatality       | Total       |
| Year       | Serious       | Repeat       | Willful       | Fatality       | Total       |

If contractor answered No to having received any citations classified as Serious, Repeat, or Willful and such violations are found during the verification process, the Contractor may be considered ineligible.

Section D – Safety Culture

Contractor must answer **ALL** questions in the below question set with either a YES or NO response. Each YES answer is worth “5” points and each NO is worth “0” points. Maximum possible scope is 100. (For example 20 questions with 20 answered YES equals 100; 15 answered YES equals 75.)

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| Minimum Required Score       |

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| **Safety Policy and Procedure Questions** |

***Click on the sheet below to open and input answers***



*Instructions to complete Section D Question Set: The embedded question set will auto calculate answers into a total score.*

1. *Place cursor on questions and right click with mouse; hover pointer over “worksheet object” and select “Open”*
2. *The form is now open and can be completed. Click on each Rating box after each question and select either YES or NO from the drop down menu.*
3. *Once all questions are answered, click the save button at the top Left of the sheet, then close the form by clicking the RED X button in upper right corner.*

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| Company Information |
|  |  |
| Name |       |
| Signature |       |
| Title |       |
| Date |       |