

Standardized Pre-Qualification Form (PQF)

GENERAL INFORMATION		
1. Company Name:	Telephone:	Fax:
Street Address:	Mailing Address:	
2. Officers	Years With Company	
President:		
Vice President:		
Treasurer:		
3. How many years has your organization been in business under your present firm name?		
4. Parent Company Name:		
City:	State:	Zip:
Subsidiaries:		
5. Under Current Management Since (Date):		
6. Contact for Insurance Information:		
Title:	Telephone:	Fax:
7. Insurance Carrier(s):		
Name	Type of Coverage	Telephone
8. Are you self insured for Worker's Compensation Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		
9. Contact for Requesting Bids:		
Title:	Telephone:	Fax:
10. PQF Completed By:		
Title:	Telephone:	Fax:

ORGANIZATION11. Form of Business: Sole Owner Partnership Corporation

13. A. Describe Services Performed:

SIC Code:

- | | |
|------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Construction | <input type="checkbox"/> Original Equipment Manufacturer and Maintenance |
| <input type="checkbox"/> Construction Design | <input type="checkbox"/> Service work (e.g., janitorial, clerical, etc.) |
| <input type="checkbox"/> Original Equipment Manufacturer and Installer | |
| <input type="checkbox"/> Project Maintenance | <input type="checkbox"/> Manpower and Resource |
| <input type="checkbox"/> Maintenance | <input type="checkbox"/> Other |

B. Work Categories

Check the categories in which you are interested in bidding and in which you are qualified to perform work. Feel free to attach additional information clarifying your capabilities and specialities.

(C) denotes work done by company employees

(S) denotes work done by subcontractors

C S 1. Air Conditioning/Refrigeration

C S 8. Field Maintenance

- Comfort Cooling/HVAC
 Refrigeration

- General
 Hot Tap/line stops
 Leak Sealing (online)
 Field Machining
 Tank/Vessel Code
 Boiler Code
 Exchanger Retubing
 Rotating Equipment
 Valve Work
 Cooling Tower
 High Alloy Welding (list type)
 Lead Lining
 Glass Lining
 Heat Treating

2. Buildings

- Remodeling
 New (steel, brick, block, other)

3. Cleaning

- Industrial
 Janitorial

4. Civil

- Concrete
 Excavation/Grading

Paving

- Asphalt
 - Concrete

 5. Demolition/Dismantling

- Pipe Fabrication
 Mobil Equipment Repair

 9. New Construction

6. Electrical

- General
 High-voltage/High-line
 Grounding Systems
 Cathodic Protection
 Heat Tracing

 10. Painting 11. Refractory/Acid Brick 12. Rigging/Equipment Erectio 13. Scaffolding

7. Inspection & Testing

- General NDT
 Infrared Scanning
 Eddy Current Testing
 Acoustic Emission
 Column Scanning
 Civil/Soils
 High Voltage Electrical
 Electrical Ground Inspection

 14. Scale Maintenance 15. Structural Steel Fab/Erection 16. Tanks - Field Erection 17. Other

<p>1 8. Instrumentation</p> <p><input type="checkbox"/> <input type="checkbox"/> General</p> <p><input type="checkbox"/> <input type="checkbox"/> DCS Control Systems</p> <p>1 9. Insulation</p> <p><input type="checkbox"/> <input type="checkbox"/> General</p> <p><input type="checkbox"/> <input type="checkbox"/> Asbestos Abatement</p> <p>20. Linings/coatings for:</p> <p><input type="checkbox"/> <input type="checkbox"/> Metal</p> <p><input type="checkbox"/> <input type="checkbox"/> Concrete</p>	<p>21. Consulting</p> <p><input type="checkbox"/> <input type="checkbox"/> - Mechanical</p> <p><input type="checkbox"/> <input type="checkbox"/> - Electrical</p> <p><input type="checkbox"/> <input type="checkbox"/> - Chemical</p> <p><input type="checkbox"/> <input type="checkbox"/> - Metallurgical</p> <p><input type="checkbox"/> <input type="checkbox"/> - Controls</p> <p><input type="checkbox"/> <input type="checkbox"/> - Other</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
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14. Describe Additional Services Performed:

15. List other types of work within the services you normally perform that you subcontract to others:

16. A. Do you normally employ? Union Personnel Non-Union Personnel Leased Personnel

If union, list trades/locals:

B. Average number of employees for last 3 years

COMPANY WORK HISTORY

17. Annual Dollar Volume for the Past Three Years:	20 ____ \$ ____	19 ____ \$ ____	19 ____ \$ ____
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18. Largest Job During the Last 3 Years: \$

19. Your Firm's Desired Project Size:	Maximum:	Minimum:
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20. D&B Financial Rating:	Annual Sales \$	Net Worth: \$
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21. Major jobs in progress:

Customer/Location	Type of Work	Size \$M	Customer Contact	Telephone

22. Major jobs completed in the past three years:

Customer/Location	Type of Work	Size \$M	Customer Contact	Telephone

23. Are there any judgments, claims or suits pending or outstanding against your company?

If yes, please attach details. Yes No

24. Are you now or have you ever been involved in any bankruptcy or reorganization proceedings?

If yes, please attach details Yes No

SAFETY & HEALTH PERFORMANCE

25. Workers Compensation Experience Modification Rate (EMR) Data

- a. EMR is:
- Interstate rate
 - Intrastate rate
 - Monopolistic State rate
 - Dual rate
- c. State of Origin: _____
- b. EMR for three last years:
- | | |
|-------|------|
| _____ | 20__ |
| _____ | 19__ |
| _____ | 19__ |
- d. EMR Anniversary Date: _____

26. Injury and Illness Data:

a. Employee hours worked last three years excluding subcontractors)	Hours / Year	20__	19__	19__
	Field			
	Total			

b. Provide the following data (excluding subcontractor) using your OSHA 200 Forms from the past three (3) years:

Notes:

- (1) Data should be the best available data applicable to the work in this region or area.
 (2) If your company is not required to maintain OSHA 200 forms, (please provide information from your Worker's Compensation insurance carrier itemizing all claims for the last 3 years)

	2000		1999		1998	
	No.	Rate	No.	Rate	No.	Rate
Injury related fatality <u>Total Col. 1 x 200,000</u> Rate = Total Employee Hours						
Lost workday case injuries involving days away from work, or days of restricted work activity, or both. <u>Total Col. 2 x 200,000</u> Rate = Total Employee Hours						
Lost workday case injuries involving days away from work. <u>Total Col. 3 x 200,000</u> Rate = Total Employee Hours						
Injuries involving medical treatment only. <u>Total Col. 6 x 200,000</u> Rate = Total Employee Hours						
Total OSHA Recordable Injury Rate <u>(Total Col. 1 + 2 + 6) x 200,000</u> Rate = Total Employee Hours						
Illness related fatality <u>Total Col. 8 x 200,000</u> Rate = Total Employee Hours						
Lost workday case illnesses involving days away from work, or days of restricted work activity, or both. <u>Total Col. 9 x 200,000</u> Rate = Total Employee Hours						
Lost workday case illnesses involving days away from work <u>Total Col. 10 x 200,000</u> Rate = Total Employee Hours						
Illnesses not involving lost workdays or restricted workdays <u>Total Col. 13 x 200,000</u> Rate = Total Employee Hours						
Total OSHA Recordable Illness Rate <u>(Total Col. 8 + 9 + 13) x 200,000</u> Rate = Total Employee Hours						
Total OSHA Recordable Injury/Illness Rate <u>(Total Col. 1 + 2 + 6 + 8 + 9 + 13) x 200,000</u> Rate = Total Employee Hours						

27. Have you received any regulatory (EPA, OSHA, etc.) citations in the last three years?
 If yes, please attach copies. Yes No

SAFETY & HEALTH MANAGEMENT

28. Highest ranking safety/health professional in the company:

Title:	Telephone:	Fax:
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29. Do you have or provide:

- | | | | |
|----|-----------------------------------------|------------------------------|-----------------------------|
| a. | Full time Safety/Health Director | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. | Full time Site Safety/Health Supervisor | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. | Full Time Job Safety/Health Coordinator | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

30. Do you have or provide:

- | | | | |
|----|-------------------------------------|------------------------------|-----------------------------|
| a. | Safety/Health incentive program | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. | Company paid safety/health training | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

SAFETY & HEALTH PROGRAMS & PROCEDURES

31. a. Do you have a written Safety and Health Program? Yes No

b. Does the program address the following key elements?

- | | | | |
|----|--------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. | Management commitment and expectations | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. | Employee participation | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. | Accountabilities and responsibilities for managers, supervisors, and employees | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. | Resources for meeting safety & health requirements | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. | Periodic safety and health performance appraisals for all employees | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. | Safety Recognition Program | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. | Hazard recognition and control | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

c. Does the program satisfy your responsibility under the law for:

- | | | | |
|----|----------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. | Ensuring your employees follow the safety rules of the facility or jobsite? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. | Advising owner of any unique hazards presented by the contractor's work, and of any hazards found by the contractor? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

32. Does the program include work practices and procedures such as:

- | | | | | | |
|----|-------------------------------------------------------------|------------------------------|-----------------------------|------------------------------|--|
| a. | Equipment Lockout and Tagout (LOTO) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| b. | Confined Space Entry | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| c. | Injury & Illness Recording | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| d. | Fall Protection | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| e. | Personal Protective Equipment | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| f. | Portable Electrical/Power Tools | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| g. | Vehicle Safety | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| h. | Compressed Gas Cylinders | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| i. | Electrical Equipment Grounding Assurance | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| j. | Powered Industrial Vehicles (Cranes, Forklifts, JLGs, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| k. | Housekeeping | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| l. | Accident/Incident Reporting | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| m. | Unsafe Condition Reporting | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| n. | Emergency Preparedness, including evacuation plan | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| o. | Waste Disposal | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |
| p. | Back Injury Prevention | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> | |

33.	Do you have written programs for the following:					
a.	Hearing Conservation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
b.	Respiratory Protection	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
	Where applicable, have employees been:					
	Trained	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	Fit tested	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	Medically approved	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
c.	Hazard Communication	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	Have employees been trained	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
d.	Program to support the contractor requirements of the OSHA Process Safety Management of Highly Hazardous Chemicals; Explosives and Blasting Agents Standard (29 CFR 1910).	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
34.	Do you have a substance abuse program?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	If yes, does it include the following?					
	• Pre-placement Testing	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	• Random Testing	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	• Testing for Cause	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	• DOT Testing	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
35.	Do your employees read, write, and understand English such that they can perform their job tasks safely without an interpreter?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
	If no, provide a description of your plan to assure that they can safely perform their jobs.					
36.	Medical					
a.	Do you conduct medical examinations for:					
	• Pre-placement	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
	• Preplacement Job Capability	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
	• Hearing Function (Audiograms)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
	• Pulmonary	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
	• Respiratory	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
b.	Describe how you will provide first aid and other medical services for your employees while on-site. Specify who will provide this service: _____					
c.	Do you have personnel trained to perform first aid and CPR?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
37.	Do you hold site safety and health meetings for:					
	Field Supervisors	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency
	Employees	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency
	New Hires	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency
	Subcontractors	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency
	Are the safety and health meetings documented?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
38.	Personal Protection Equipment (PPE)					
a.	Is applicable PPE provided for employees?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
b.	Do you have a program to assure that PPE is inspected and maintained?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
39.	Do you have a corrective action process for addressing individual safety and health performance deficiencies?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	

40. Equipment and Materials:

a. Do you have a system for establishing applicable health, safety, and environmental specifications for acquisition of materials and equipment? Yes No N/A

b. Do you conduct inspections on operating equipment (e.g., cranes, forklifts, JLGs) in compliance with regulatory requirements? Yes No N/A

c. Do you maintain operating equipment in compliance with regulatory requirements? Yes No N/A

d. Do you maintain the applicable inspection and maintenance certification records for operating equipment? Yes No N/A

41. Subcontractors

Do you use subcontractors? (If no, skip to question 43) Yes No

a. Do you use safety and health performance criteria in selection of subcontractors? Yes No N/A

b. Do you evaluate the ability of subcontractors to comply with applicable health and safety requirements as part of the selection process? Yes No N/A

c. Do your subcontractors have a written Safety & Health Program? Yes No N/A

d. Do you include your subcontractors in:

- Safety & Health Orientation Yes No N/A
- Safety & Health Meeting Yes No N/A
- Inspections Yes No N/A
- Audits Yes No N/A

42. Inspections and Audits

a. Do you conduct safety and health inspections? Yes No

b. Do you conduct safety and health program audits? Yes No

c. Are corrections of deficiencies documented? Yes No

SAFETY & HEALTH TRAINING

43. Safety & Health Orientation

		<u>New Hires</u>			<u>Supervisors</u>			
a. Do you have a Safety & Health Orientation Program for new hires and newly hired or promoted supervisors?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
b. Does program provide instruction on the following:								
• New Worker Orientation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Safe Work Practices	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Safety Supervision	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Toolbox Meetings	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Emergency Procedures	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• First Aid Procedures	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Incident Investigation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Fire Protection and Prevention	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Safety Intervention	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Hazard Communication	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
c. How long is the orientation program? _____ Hours								
d. Are written exams given? _____ If no, how do you verify comprehension? _____ (Written test, Craft Test, Performance Test, Job Monitoring, Other - List)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>				

44. Safety & Health Training

a. Do you know the regulatory safety and health training requirements for your employees? Yes No

b. Have your employees received the required safety and health training and retraining and is it documented? Yes No

- c. Do you have a specific safety and health training program for supervisors? Yes No
- d. Are all employees trained in the work practices needed to safely perform his/her job? Yes No
- e. Is each employee instructed in the known potential of fire, explosion, or toxic release hazards related to his/her job, the process and the applicable provisions of the emergency action plan? Yes No

CRAFT TRAINING & ASSESSMENT

Data as of _____

- Notes
1. Data should be the best available applicable to the workforce in this region or area
 2. Skills Assessment means the ABC/CMEF skill assessment process.
 3. Skill assessment is not required for helper/trainer/laborers or for craft employees who have either 1) completed Wheels of Learning (WOL) or Department of Labor Bureau of Apprenticeship Training (DOL BAT) or 2) are participating in WOL or DOL

BAT.

45. WORKFORCE	#	%
a. Journeymen Craftsmen	_____	_____
b. Helper/Trainees	_____	_____
c. Total Workforce	_____	_____

- 46. TRAINING**
- a. Do you have craft training records for employees? Yes No
- b. % of Craft Employees who have completed Wheels of Learning or DOL Bureau of Apprenticeship Training _____%
- c. % of Craft Employees presently enrolled in Wheels of Learning or DOL BAT _____%
- d. If employees have not completed or are not enrolled in Wheels of Learning or DOL BAT have they been trained in appropriate job skills (attach explanation) Yes No

- 47. ASSESSMENT**
- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| | # | % |
| a. Craftsmen who have been assessed through the craft skills assessment process | _____ | _____ |
| b. Craftsmen who have been assessed with "no deficiencies" identified | _____ | _____ |
| c. Craftsmen who have been assessed with training (WOL modules) identified | _____ | _____ |
| d. Craftsmen who have not been assessed through the skills assessment | _____ | _____ |
| e. For those employees for whom there is not a skills assessment available, do you have a process to assess the skills of your workers to assure they are qualified (attach explanation) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Are employees job skills certified where required by regulatory or industry consensus standards. (attach a list of the crafts which have been certified) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

48. HELPER/TRAINEES	#	%
a. Helpers who are enrolled in Wheels of Learning or DOL Bureau of Apprenticeship Training	_____	_____
b. Helpers who are not enrolled in WOL or DOL BAT	_____	_____

MANAGEMENT TRAINING & ASSESMENT

#	% Tol.	No. of Hours over last 24	Months*
49. FOREMEN			
a.	Foremen who have completed a recognized foreman continuing education program	_____	_____
b.	Foreman who are not enrolled in a recognized foreman continuing education program	_____	_____
50. SUPERVISORS			
a.	Supervisors who have completed a recognized supervisors continuing education program	_____	_____
b.	Supervisors who are not enrolled in a recognized supervisors continuing education program	_____	_____
51. PROJECT MANAGERS			
a.	Project Managers who have completed a recognized project manager continuing education program	_____	_____
b.	Project Managers who are not enrolled in a recognized project manager continuing education program	_____	_____
52. ESTIMATORS			
a.	Estimators who have completed a recognized estimating continuing education program	_____	_____
b.	Estimators who are not enrolled in a recognized estimating continuing education program	_____	_____
53. SENIOR MANAGERS			
a.	Senior managers who have completed a recognized continuing education program.	_____	_____
b.	Senior managers who are not enrolled in a recognized continuing education program	_____	_____
54. ASSESSMENT			
	For management level employees for whom there is not a skills assessment available, do you have a process to assess the skills of your workers to assure they are qualified (attach explanation)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

*No. of Hours refers to the total length of the program(s) over the last two years

INFORMATION SUBMITTAL

Please provide copies of checked (4) item with the completed Prequalification Form:

- EMR documentation from your insurance carrier
- Insurance Certificate(s)
- OSHA 200 Logs (Past 3 Years)
- Safety & Health Program
- Safety & Health Incentive Program
- Substance Abuse Program (Include Substances Tested & Levels)
- Hazard Communication Program
- Respiratory Protection Program
- Housekeeping Policy
- Accident/Incident Investigation Procedure
- Unsafe Condition Reporting Procedure
- Safety & Health Inspection Form
- Safety & Health Audit Procedure or Form
- Safety & Health Orientation (Outline)
- Safety & Health Training Program (Outline)
- Example of Employee Safety & Health Training Records
- Safety & Health Training Schedule (Sample)
- Safety & Health Training for Supervisors (Outline)

- Quality Control Process methods or manual
- Quality Assurance Plan

- Continuing Education Courses attended by management level employees over last three years

Attach a list of major equipment (e.g., cranes, JLGs, forklifts) your company has available for work and the method of establishing competency to operate.

Note: Owner checks items to be provided with Pre-Qualification Form.

This document must be signed by a company officer.

Signature

Title

Date

Print Name

