

Subcontractor

Bid Pre-Qualification Form

Date: _____

Name of Company: _____

Street Address: _____

City: _____ State: _____ Zip _____

Mailing Address (if different) _____

Phone # _____ Fax # _____

Primary Contact: _____ E-mail: _____

Secondary Contact: _____ E-mail: _____

Company Website: _____

Vendor is a: (circle one) Supplier Subcontractor

Company Operations

Federal Tax ID # _____ State Sales Tax Registration # _____

State Unemployment Insurance # _____ Year Company Started _____

Type Of Company: Corp. Partnership Proprietorship Sub Corp.

If incorporated what state? _____ Date of Incorporation _____

Under what other names has your company operated under? _____

Union Affiliations: _____

Is your Company: MBE WBE DBE If so, certified by _____

MBE/WBE Participation in work which you subcontracted for last three years?

MBE _____% WBE _____%

Minority/Female workforce participation average percentage utilization for the last three years?

MIN _____% FEM _____%

Do you have a current approved Ohio BWC Drug Free Workplace Program in Place? _____

What percentage of the Company's work is normally subcontracted _____%

What is the largest contract your Company has completed? _____

What is your expected annual volume this year \$ _____ # of Projects _____

Has your Company or any of its principals ever petitioned for bankruptcy, failed in business defaulted or been terminated on a contract awarded to you? _____ Yes _____ No

If yes please explain: _____

Have any of the owners, officers or major stockholders of your Company ever been indicted or convicted of any felony or other criminal conduct? _____ Yes _____ No

If yes please explain: _____

Has your Company ever been disbarred or otherwise precluded from pursuing public work or ever been found to be non-responsive by a public agency? _____ Yes _____ No

If yes please explain: _____

Has your Company ever had a claim made against it for improper, delayed, defective or non-compliant work or failure to meet warranty obligations? _____ Yes _____ No

If yes please explain: _____

Is your Company or any of its owners, officers, or major shareholders currently involved in any arbitration or litigation? _____ Yes _____ No

If yes please explain: _____

Does your Company have any outstanding judgments or claims against it? ____Yes ____No

If yes please explain: _____

Please list any litigations brought against your Company in the past five years asserting that you failed to make payments to anyone. _____

Finances/Insurances

Name of the Company's Bank _____

Address _____

Phone # _____ Contact Person _____

What is Company's Dun & Bradstreet # _____

List three of your major suppliers:

Name: _____

Address: _____ Phone # _____

Contact Person _____

Name: _____

Address: _____ Phone # _____

Contact Person _____

Name: _____

Address: _____ Phone # _____

Contact Person _____

List three contractors that you do business with:

Name: _____

Address: _____ Phone # _____

Job Name _____ Contact Person _____

Name: _____

Address: _____ Phone # _____

Job Name _____ Contact Person _____

Name: _____

Address: _____ Phone # _____

Job Name _____ Contact Person _____

Bonding Company Name _____

Contact Person _____

Bonding Capacity _____ Aggregate _____

Date of Last Bond _____ Amount \$ _____

Bond Rate _____%

Commercial General Liability

Insurance Carrier: _____

Policy Form Occurrence Claims Made Tail Coverage _____ Yrs.

Are there exclusions from standard CGL Policy? _____ Yes _____ No

If yes what are they: _____

Limits:	Current	Max Obtainable
General Aggregate	\$ _____	\$ _____
Products-Comp/Op Agg.	\$ _____	\$ _____
Personal/Adv. Injury	\$ _____	\$ _____
Each Occurrence	\$ _____	\$ _____
Med. Exp. Any 1 person	\$ _____	\$ _____
Fire Damage any 1 fire	\$ _____	\$ _____

Deductible: \$ _____

Excess Liability

Insurance Carrier _____

Umbrella? Yes No

If no, explain form: _____

	Current	Max Obtainable
Each Occurrence	\$ _____	\$ _____
Aggregate	\$ _____	\$ _____

Workers Compensation and Employer's Liability

Insurance Carrier _____

Limits \$ _____

E.L Each Accident \$ _____

E.L Disease-Policy Limit \$ _____

E.L Disease Each Employee \$ _____

Is your company also actively covered by the Ohio BWC? Yes or No

BWC Policy Number _____

Is your company recognized by the BWC as being an "Approved Contractor" under the Drug Free Workplace? Yes No

Automobile Liability

Insurance Carrier _____

	Current	Max Obtainable
Combined Single Limit	\$ _____	\$ _____

Bodily Injury (per person) \$ _____ \$ _____
 Bodily Injury (per accident) \$ _____ \$ _____
 Property Damage \$ _____ \$ _____

Professional Liability Insurance

Insurance Carrier: _____

Office Policy Limits: \$ _____ Deductible: \$ _____

Project Specific Limit Available: \$ _____

Extended Reporting Period (Tail) _____ Years

Prior Acts: ___ Yes ___ No

Safety Information

Name of Person Responsible for Safety _____

Phone # _____ E-Mail _____

Qualifications of Person Responsible for Safety _____

The Company's EMR (experience modification rate) for the past three years.

Year/Rate	Year/Rate	Year/Rate
_____/_____ _____	_____/_____ _____	_____/_____ _____

Complete injury illness records for the past three years listed above (300 Logs).

Year	_____	_____	_____
# Of Fatalities	_____	_____	_____
# Of Lost Workdays Cases	_____	_____	_____
# Of Restricted Cases	_____	_____	_____
# Of Lost Work Days	_____	_____	_____
# Of Restricted Days	_____	_____	_____
# Of Medical Only Cases	_____	_____	_____
Total # Of Hours Worked	_____	_____	_____

Total Incident Rate (Total Number of Recordable Accidents x 200,000 / Total # Hours Worked)

DART (# of Cases in Restricted + # of Cases in Lost Work Days x 200,000 / Total # Hours Worked) _____

How many OSHA Citation(s) has your Company received in the last three years.

Year	_____	_____	_____
# of Citations	_____	_____	_____

Where any of the citation(s) willful? _____ Yes _____ No

Where any of the citation(s) repeat? _____ Yes _____ No

Please give a brief description of the citation(s) _____

Programs

Does your safety person inspect your projects _____ Yes _____ No Frequency _____

Are these inspections in written form _____ Yes _____ No

Does your Company have a written Safety & Health Policy? _____ Yes _____ No

Does your Company have a written Substance Abuse Policy? _____ Yes _____ No

Does your Company have a written Disciplinary Policy? _____ Yes _____ No

Training

Does your Company provide new hire training? _____ Yes _____ No

Does your Company do Safety Talks in the field? _____ Yes _____ No

If yes, how often? _____

How many employees are trained to the 10 hour 16 hour 30 hour levels

10 Hour _____ 16 hour _____ 30 hour _____

Accident Investigations

Does your Company conduct accident investigations? _____ Yes _____ No

If yes, are they recorded in written form _____ Yes _____ No

Does your Company analyze accidents annually? _____ Yes _____ No

If yes, what were your lead accident causes last year? _____

If yes, what were your lead type of accidents last year? _____

Does your Company set annual safety goals? _____ Yes _____ No

If yes, list this year goals _____

Names of personnel and their positions filling out this form. _____

Please attach to this form the following documents.

- _____ **W9**
- _____ **General Liability Insurance Certificate**
- _____ **BWC Certificate**
- _____ **Edge Certification if Applicable**