

**1 GENERAL BUSINESS INFORMATION**

Company Name:

Physical Address:

City:

State:

Zip or Postal Code:

Telephone No:

Fax No:

Website Address:

Requests For Information

Name:

E-mail Address:

**2 ORGANIZATION PERSONNEL**

Officer's Name:

Title:

Length of Service:

**3 INSURANCE**

Name of Insurance Company:

Address:

City:

State:

Zip:

Insurance Company Contact:

Telephone No:

|                                      |  |
|--------------------------------------|--|
| Total General Liability per Project: | Total Excess/Umbrella Liability per Project: |
|--------------------------------------|--|

#### 4 Contractor Safety

Questions relating to your Contractor Safety Requirements and Qualifications should be directed to Rob Razzano, EHS Director at [rrazzano@songernet.com](mailto:rrazzano@songernet.com) and/or 724-730-5074.

|   |                                   |
|---|-----------------------------------|
| Standard Industry Classification (SIC) number(s): | or corresponding NAICS number(s): |
|---|-----------------------------------|

#### Experience Modification Rating (EMR)(TARGET <1.0)

(This is an annual safety rating of how a specific contractor compares to other contractors, in the same type of contracting, in the state where the contractor is working. Contractor should have this rating since it is provided by his company.) Show your EMR as applicable for this current year and for the last two years, as follows:

| EMR For                  | This Year | Last Year | Year Before |
|--------------------------|-----------|-----------|-------------|
| Intrastate (Home State): |           |           |             |
| Interstate:              |           |           |             |

#### Accident Experience:

|   | This Year | Last Year | Year Before  |
|---|-----------|-----------|--|
| # of Total Recordable (Medical)   |           |           |  |
| # of Restricted Duty  |           |           |  |
| # of Lost Time Injuries   |           |           |  |
| # of Days Lost  |           |           |  |
| Has your company experienced any fatalities in the last three years?<br>(If YES provide attachment) |           |           | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### OSHA Incident Rates

Recordable Rate / Lost Time Rate = Number of injuries x 200,000 divided by Total Man-Hours Worked

Severity = Number of lost days x 200,000 divided by Total Man-Hours Worked

Note: The number of recordable injuries includes the number of light duty plus lost time.

|                               | This Year | Last Year | Year Before |
|-------------------------------|-----------|-----------|-------------|
| Recordable Rate (Target <5.0) |           |           |             |
| Lost Time Rate (Target <3.0)  |           |           |             |
| Severity                      |           |           |             |

### Safety & Health Management

|  |                              |  |
|--|------------------------------|--|
| Highest ranking safety/health professional in the company: | Name:                        | Title:   |
| Telephone:   | E-Mail:                      |  |
| Comments:  |                              | <b>N/A = Not Applicable to contractor work scope</b> |
| <b>Do you have:</b>  |                              |  |
| a. Full-time Safety/Health Director?                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No                          |
| b. Full-time Site Safety/Health Supervisor?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No                          |
| c. Full-time Job Safety/Health Coordinator?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No                          |
| d. Documented health and safety training?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                          |

**Safety & Health Programs & Procedures – Forward copy of Health and Safety Program to [rrazzano@songernet.com](mailto:rrazzano@songernet.com)**

|   |                              |                             |
|---|------------------------------|-----------------------------|
| I. Do you have a written Health & Safety Program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|------------------------------|-----------------------------|

|   |  |
|---|--|
| <b>II. Does the program address the following key elements?</b> | <b>N/A = Not Applicable to contractor work scope</b> |
|---|--|

|     |  |           |                              |                             |                              |
|-----|--|-----------|------------------------------|-----------------------------|------------------------------|
| 1.  | Safety procedures for host-employer facilities                                 | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 2.  | Management commitment and expectations   |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 3.  | Accountabilities and responsibilities for managers, supervisors, and employees |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 4.  | Resources for meeting safety and health requirements                           |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 5.  | Hazard recognition and control   |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 6.  | Attitude and Culture   |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 7.  | Accountability   |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 8.  | Pre-Work Planning – Job Briefings, Job Safety Analysis, Hazard Assessment      |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 9.  | Safety Training  |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 10. | Evaluation/Auditing of safety measures   |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 11. | Safety Audits and Inspections  |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 12. | Adverse Weather including Evacuation and Notification Procedures               |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

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

|    |                                      |           |                              |                             |                              |
|----|--------------------------------------|-----------|------------------------------|-----------------------------|------------------------------|
| a. | Accident Reporting and Investigation | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b. | Aerial Lifts                         |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| c. | Asbestos                             |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| d. | Bloodborne Pathogens                 |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| e. | Compressed Gas                       |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

|    |                                       |                              |                             |                              |
|----|---------------------------------------|------------------------------|-----------------------------|------------------------------|
| f. | Concrete & Masonry                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| g. | Confined Space Entry                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| h. | Cranes                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| i. | Demolition                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| j. | Electrical                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| k. | Excavation & Trenching                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| l. | Fall Protection, Prevention & Rescue  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| m. | Fire Protection & Prevention          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| n. | Gas Hazards                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| o. | Grounding                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| p. | Lock Out-Tag Out                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| q. | Hand & Power Tools                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| r. | Hazard Response                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| s. | Hexavalent Chromium                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| t. | Housekeeping & Sanitation             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| u. | Inorganic Arsenic                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| v. | Ladders & Stairs                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| w. | Lead Based Paint                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| x. | Lock Out/Tag Out                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| y. | Personal Protective Equipment (PPE)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| z. | Powered Industrial Trucks (forklifts) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

|  |   |                              |                              |                              |                              |
|--|---|------------------------------|------------------------------|------------------------------|------------------------------|
| aa.  | Pressure Testing  |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| bb.  | Property Damage   |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| cc.  | Radioactive Sources                                       |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| dd.  | Rigging   |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| ee.  | Roofing   |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| ff.  | Scaffolds   |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| gg.  | Steel Erection  |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| hh.  | US Steel S-001  |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| ii.  | Utilization of Safety Tape, Signs, Barricading & Flagging |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| jj.  | Welding & Cutting   | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |                              |
| <b>IV. Do you have written programs for the following:</b> |   |                              |                              |                              |                              |
| a.   | Abrasive Blasting   | Comments:                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| b.   | Explosive Blasting  |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| c.   | Hearing Conservation                                      |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| d.   | Hazard Communication                                      |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| e.   | Respiratory Protection                                    |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| <b>f. Where applicable, have employees been:</b>           |   |                              |                              |                              |                              |
| 2.   | Trained   | Comments:                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| 3.   | Fit tested  |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |
| 4.   | Medically approved  |                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No  | <input type="checkbox"/> N/A |

**V. Do you have a substance abuse program? If yes, does it include the following:**

|    |                       |           |                              |                             |                              |
|----|-----------------------|-----------|------------------------------|-----------------------------|------------------------------|
| a. | Pre-placement testing | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b. | Random testing        |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| c. | Testing for cause     |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

**VI. Medical**

|    |  |           |                              |                             |                              |
|----|--|-----------|------------------------------|-----------------------------|------------------------------|
| a. | Do you have personnel trained to perform first aid and CPR?                                | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b. | Do you provide first aid, CPR and other medical services for your employees while on site? |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

**VII. Meetings: Do you hold site safety and health meetings for...**

|    |                   |           |                              |                             |                              |
|----|-------------------|-----------|------------------------------|-----------------------------|------------------------------|
| a. | Field Supervisors | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b. | Employees         |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| c. | New Hires         |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| d. | Subcontractors    |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

**VIII. Equipment and Materials**

|    |   |           |                              |                             |                              |
|----|---|-----------|------------------------------|-----------------------------|------------------------------|
| a. | Do you conduct inspections on operating equipment (e.g., cranes, forklifts, JLGs) in compliance with regulatory requirements? | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b. | Do you maintain operating equipment in compliance with regulatory requirements?   |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| c. | Do you maintain the applicable inspection and maintenance and certification records for operating equipment?                  |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

**IX. Subcontractors**

|    |  |           |                              |                             |                              |
|----|--|-----------|------------------------------|-----------------------------|------------------------------|
| a. | Do you use subcontractors?   | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b. | Do you use safety and health performance criteria in selection of subcontractors?  |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| c. | Do you evaluate ability of subcontractors to comply with applicable health and safety requirements as part of selection process? |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

|   |   |           |                              |                             |                              |
|---|---|-----------|------------------------------|-----------------------------|------------------------------|
| d.  | Do your subcontractors have a written Safety & Health program?  |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| <b>e. Do you include your contractors in:</b> |   |           |                              |                             |                              |
| 1.  | Safety & Health Orientation   | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 2.  | Safety & Health Meetings and Inspections  |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| 3.  | Audits  |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| <b>X. Inspections and Audits</b>              |   |           |                              |                             |                              |
| a.  | Do you conduct safety and health inspections?   | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b.  | Do you conduct safety and health program audits?  |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| c.  | Are corrections of deficiencies documented?   |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| d.  | Do you have a Disciplinary/Corrective action processes for addressing safety and health performance deficiencies? |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

### Safety & Health Training

#### I. Craft Training

|    |  |           |                              |                             |                              |
|----|--|-----------|------------------------------|-----------------------------|------------------------------|
| a. | Have employees been trained in appropriate job skills?   | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b. | Do you have a process to assess the skills of your workers to assure they are qualified?         |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| c. | Are employees job skills certified where required by regulatory or industry consensus standards? |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

#### II. Safety & Health Training

|    |  |           |                              |                             |                              |
|----|--|-----------|------------------------------|-----------------------------|------------------------------|
| a. | Do you know the regulatory safety and health training requirements for your employees?     | Comments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| b. | Have your employees received the required safety and health training and is it documented? |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| c. | Do you have a specific safety and health training program for supervisors?                 |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| d. | Are all employees training in the work practices needed to safely perform his/her job?     |           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |





**SONGER CORPORATE SAFETY**  
**SUBCONTRACTOR PRE-QUALIFICATION FORM**

**5 References**

List major clients that you have performed work or services for within the past three (3) years.

|          |           |          |               |
|----------|-----------|----------|---------------|
| Company: | Location: | Contact: | Telephone No: |
|          |           |          |               |

The information provided herein is true and sufficiently complete so as not to be misleading

|                                    |                 |       |
|------------------------------------|-----------------|-------|
| Signature of Information Provider: | Title/Position: | Date: |
|                                    |                 |       |

**6 APPROVAL (Official SSSI Use Only) – Subcontractors DO NOT Complete Section 6**

|              |                              |                             |
|--------------|------------------------------|-----------------------------|
| a. Approved: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|--------------|------------------------------|-----------------------------|

|              |
|--------------|
| b. Comments: |
|              |

|                            |                 |       |
|----------------------------|-----------------|-------|
| Signature of SSSI Auditor: | Title/Position: | Date: |
|                            |                 |       |