McMurray Stern
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SUB-CONTRACTOR/VENDOR PRE-QUALIFICATION QUESTIONNAIRE

GENERAL INFORMATION

1.	Company Name/Contractors License No.:	Telephone:	SIC(s):
	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:		
	Name:	Title:	Telephone:
7.	Insurance Carrier(s):		

Name	Type of Coverage	Telephone

8. Are you self insured for Worker's Compensation Insurance? Yes ☐ No ☐

9. Contact for HSE Information:
Name: Title: Telephone:

10. Form Completed By:
Name: Title: Telephone:

Please describe the type (s) of services your organization provides:

SAFETY & HEALTH PERFORMANCE

11. Workers Compensation Experience Modification Rate (EMR) Data

a. Current EMR is:

Interstate rate

Intrastate rate

Monopolistic State rate

Dual rate

b. EMR for three last years:

2009 =
2010=
2011 =

c. State of Origin:

d. EMR Anniversary Date:

12. Injury and Illness Data:

a. Employee hours worked last three years excluding subcontractors)

Hours / Year	2009	2010	2011
Field			
Total			

b. Provide the following data (excluding subcontractor) using your OSHA 200 or 300 Forms from the past three (3) years:

	2009		2010		2011	
	No.	Rate	No.	Rate	No.	Rate
Number of Injury related fatalities: Rate = Number of fatalities x 200,000 / Total Employee Hours						
Injuries involving days away from work: Rate = Number of cases with days away from work x 200,000 / Total Employee Hours						
Total OSHA Recordable Injury/Illness Rate: Rate = Total number of injuries and illnesses x 200,000 / Total Employee Hours						

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 300 forms, please provide information from your Worker's Compensation insurance carrier itemizing all claims for the last three years.

3213. Have you received any regulatory (EPA, OSHA, etc.) citations in the last three years? If yes, please attach copies. Yes ☐ No ☐

14. Employee miles driven in company-owned or -provided vehicles (Fleet mileage) in the last year:

15. Number of vehicle accidents reported in company-owned or -provided vehicles in the last year:

SAFETY & HEALTH MANAGEMENT

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

Name:	Title:	Telephone:

317. Do you have or provide:

a. Full time Safety/Health Director Yes ☐ No ☐

b. Full time Site Safety/Health Supervisor Yes ☐ No ☐

c. Full Time Job Safety/Health Coordinator Yes ☐ No ☐

18. Do you have or provide:

a. Safety/Health incentive program Yes ☐ No ☐

b. Company paid safety/health training Yes ☐ No ☐

SAFETY & HEALTH PROGRAMS & PROCEDURES

19. a. Do you have a written Safety and Health Program?	Yes ☐	No ☐	N/A ☐
b. Does the program address the following key elements?			
• Management commitment and expectations	Yes ☐	No ☐	N/A ☐
• Employee participation	Yes ☐	No ☐	N/A ☐
• Accountabilities and responsibilities for managers, supervisors, and employees	Yes ☐	No ☐	N/A ☐
• Resources for meeting safety & health requirements	Yes ☐	No ☐	N/A ☐
• Periodic safety and health performance appraisals for all employees	Yes ☐	No ☐	N/A ☐
c. Does the program satisfy your responsibility under the law for:			
• Ensuring your employees follow the safety rules of the facility	Yes ☐	No ☐	N/A ☐
• Advising owner of any unique hazards presented by the contractor's work, and of any hazards found by the contractor?	Yes ☐	No ☐	N/A ☐

20. Does the program include work practices and procedure such as:
    - a. Accident/Incident Reporting — Yes ☐ No ☐ N/A ☐
    - b. Near Miss/Unsafe Condition Reporting — Yes ☐ No ☐ N/A ☐
    - c. Injury & Illness Reporting — Yes ☐ No ☐ N/A ☐
    - d. Fall Protection — Yes ☐ No ☐ N/A ☐
    - e. Personal Protective Equipment — Yes ☐ No ☐ N/A ☐
    - f. Portable Electrical/Power Tools — Yes ☐ No ☐ N/A ☐
    - g. Driving Safety Program/Cell Phone Use Policy — Yes ☐ No ☐ N/A ☐
    - h. Compressed Gas Cylinders — Yes ☐ No ☐ N/A ☐
    - i. Electrical Equipment Grounding Assurance — Yes ☐ No ☐ N/A ☐
    - j. Powered Industrial Vehicles (Cranes, Forklifts, JLGs, etc.) — Yes ☐ No ☐ N/A ☐
    - k. Housekeeping — Yes ☐ No ☐ N/A ☐
    - l. Confined Space Entry — Yes ☐ No ☐ N/A ☐
    - m. Equipment Lockout and Tagout (LOTO) — Yes ☐ No ☐ N/A ☐
    - n. Emergency Preparedness, including evacuation plan — Yes ☐ No ☐ N/A ☐
    - o. Waste Disposal/Spill Prevention — Yes ☐ No ☐ N/A ☐
    - p. Back Injury Prevention — Yes ☐ No ☐ N/A ☐
21. Do you have written programs for the following:
    - a. Hearing Conservation — Yes ☐ No ☐ N/A ☐
    - b. Respiratory Protection — Yes ☐ No ☐ N/A ☐
        - If applicable, have employees been:
            - Trained — Yes ☐ No ☐ N/A ☐
            - Fit Tested — Yes ☐ No ☐ N/A ☐
            - Medically approved — Yes ☐ No ☐ N/A ☐
    - c. Hazard Communication (HazCom)
        - Have your employees been trained in HazCom — Yes ☐ No ☐ N/A ☐
    - d. Program to support the contractor requirements of the OSHA Process Safety Management of Highly Hazardous Chemicals (29 CFR 1910.119) — Yes ☐ No ☐ N/A ☐
    - e. Bloodborne Pathogens — Yes ☐ No ☐ N/A ☐
22. Do you have a substance abuse program? — Yes ☐ No ☐ N/A ☐
    - If yes, does it include the following?
        - Pre-placement Testing — Yes ☐ No ☐
        - Random Testing — Yes ☐ No ☐
        - Testing for Cause — Yes ☐ No ☐
        - DOT Testing — Yes ☐ No ☐ N/A ☐
23. Do your employees read, write, and understand English such that they can perform their job tasks safely without an interpreter? — Yes ☐ No ☐
    - If no, provide a description of your plan to assure they understand and can safely perform their jobs.
24. Medical
    - a. Do you conduct medical examinations for:
        - Pre-placement Testing — Yes ☐ No ☐ N/A ☐
        - Preplacement Job Capability — Yes ☐ No ☐ N/A ☐
        - Hearing Function (Audiograms) — Yes ☐ No ☐ N/A ☐
        - Pulmonary — Yes ☐ No ☐ N/A ☐
        - Respiratory — Yes ☐ No ☐ N/A ☐
    - b. Who is your company's Occupational Health Facility who will provide medical treatment for your employees while on-site?
        - Facility Name:
        - Address:
        - Phone Number:
        - Name of Contact:
    - c. Do you have personnel trained to perform first aid and CPR? — Yes ☐ No ☐ N/A ☐
25. Do you hold site safety and health meetings for:
    - Field Supervisors — Yes ☐ No ☐ N/A ☐
    - Employees — Yes ☐ No ☐ N/A ☐
    - Subcontractors — Yes ☐ No ☐ N/A ☐

Question	Yes	No	N/A
Are the safety and health meetings documented?	Yes ☐	No ☐	N/A ☐
26. Personal Protection Equipment (PPE)			
a. Is applicable PPE provided for employees?	Yes ☐	No ☐	N/A ☐
b. Do you have a program to assure that PPE is inspected and maintained?	Yes ☐	No ☐	☐
27. Do you have a corrective action process for addressing individual safety and health performance deficiencies?	Yes ☐	No ☐	☐
28. 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 ☐
29. Subcontractors: Do you use subcontractors? (If no, skip to next question.)	Yes ☐	No ☐	N/A ☐
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 Orientations?	Yes ☐	No ☐	N/A ☐
○ Safety & Health Meetings?	Yes ☐	No ☐	N/A ☐
○ Inspections and/or Audits?	Yes ☐	No ☐	N/A ☐
30. Inspections and Audits:			
a. Do you conduct safety and health inspections?	Yes ☐	No ☐	N/A ☐
b. Do you conduct safety and health program audits?	Yes ☐	No ☐	N/A ☐
c. Are corrections of deficiencies documented?	Yes ☐	No ☐	N/A ☐

SAFETY & HEALTH TRAINING

Question	Yes	No	N/A
31. Craft Training:			
a. Have employees been trained in appropriate job skills?	Yes ☐	No ☐	N/A ☐
b. Do you have a process to assess the skills of your workers to assure they are qualified?	Yes ☐	No ☐	N/A ☐
c. Are employees job skills certified where required by regulatory or industry consensus standards?	Yes ☐	No ☐	N/A ☐
d. List crafts which have been certified:			
32. Safety & Health Orientation:			
a. Do you have a Safety & Health orientation Program for new hires and newly hired/promoted supervisors?	Yes ☐	No ☐	N/A ☐
b. Does program provide instruction on the following:			
○ New Worker Orientation	Yes ☐	No ☐	N/A ☐
○ Safe Work Practices	Yes ☐	No ☐	N/A ☐
○ Safety Supervision	Yes ☐	No ☐	N/A ☐
○ Toolbox Meetings	Yes ☐	No ☐	N/A ☐
○ Emergency Procedures	Yes ☐	No ☐	N/A ☐
○ First Aid Procedures	Yes ☐	No ☐	N/A ☐
○ Incident Investigation	Yes ☐	No ☐	N/A ☐
○ Fire Protection and Prevention	Yes ☐	No ☐	N/A ☐
○ Safety Intervention	Yes ☐	No ☐	N/A ☐
○ Hazard Communication	Yes ☐	No ☐	N/A ☐
c. How long is the orientation program (in hours)?			
d. Are written exams given?	Yes ☐	No ☐	N/A ☐
If no, how do you verify comprehension?			
33. Safety & Health Training			
a. Do you know the regulatory safety and health training requirements for your employees?	Yes ☐	No ☐	N/A ☐
b. Have your employees received the required safety and health training and retraining and is it documented?	Yes ☐	No ☐	N/A ☐
c. Do you have a specific safety and health training program for supervisors?	Yes ☐	No ☐	N/A ☐
d. Are all employees trained in the work practices needed to safely perform their job?	Yes ☐	No ☐	N/A ☐

e. Do you have a specific defensive driving training program? Yes☐ No☐ N/A☐

INFORMATION SUBMITTAL

Please provide copies of checked (✓) item with the completed PQF:

EMR documentation from your insurance carrier	√
Insurance Certificate(s)	√
OSHA 200/300 Logs (Past 3 Years)	√
Safety & Health Program and/or Manual	√
Substance Abuse Program	√
Hazard Communication Program	☐
Respiratory Protection Program	☐
Lockout/Tagout Program	☐
Fall Protection Program	☐
Confined Space Entry Program	☐
Excavating and Trenching Program	☐
Hot Work Program	☐
Crane/Hoist/Lifting Safety Program	☐
Work-Related Illness and Injury Case Management Plan	√
Other (Specify)	☐

This document must be signed by a company officer.

Title	Signature	Date

Guidelines for a Successful Work-Related Injury and Illness Case Management Program

Please respond to the following:

1) Please identify the local Occupational Health and Medical Facility that may be utilized while working at BP La Palma.
   -

2) Please identify how the information regarding injuries and your case management program is communicated to supervisors and/or employees?
   -

3) Does your company / organization mandate that all employees are treated at the Occupational Health and Medical Facility unless it is life or limb threatening?
   Yes No

4) Identify how your company manages injuries (First Aids, OSHA Recordable, Restricted Work, Days Away From Work (DAFW))?
   a. Do you have modified duty work available?
      -
   b. Do you communicate the job duties of the injured employee to the doctor, and verify in writing that you have modified duty available?
      -
   c. Does the supervisor or manager go to the clinic with the employee?
      -
   d. Does your Occupational Health Clinic communicate the status of the employee in writing?
      -

5) What are your company's injury notification procedures (including the client notification)?
   -

6) How is your follow-up care managed?
   -

7) How are your ***Lessons Learned*** recorded and communicated through out your organization?
   -

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Please document responses on a separate sheet or form if needed.

HSSE Contractor Approval Status Checklist

Name of Contractor:

Contact Name: **Number:**
Name of Reviewer:

INFORMATION SUBMITTAL			
Please provide a check (✓) for each item as it applies to the contractor:	Done		Notes:
THE FOLLOWING SECTIONS ARE MANDATORY BY ALL TRADES			
EMR documentation from insurance carrier			
Insurance Certificate(s)			
OSHA 200/300 Logs (Past 3 Years)			
Safety & Health Program and/or Manual			
Substance Abuse Program			
THE FOLLOWING SECTIONS MUST BE CHECKED AS APPLICABLE			
Hazard Communication Program			
Respiratory Protection Program			
Lockout/Tagout Program			
Fall Protection Program			
Confined Space Entry Program			
Excavating and Trenching Program			
Hot Work Program			
Crane/Hoist/Lifting Safety Program			
Work-Related Illness and Injury Case Management Plan			
Other (Specify)			