

# Subcontractor Information Form

## COMPANY DETAILS

DATE COMPLETED: \_\_\_\_\_

Company Name		
Telephone	Fax	Email Address
Street Address		
City	State	Zip
Is this address the: <input type="checkbox"/> Main Office <input type="checkbox"/> Regional Office <input type="checkbox"/> Branch Office		
Please check one: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation		
Are you: <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Both		
Name of Parent Company		Federal Tax ID Number
Address of Parent Company		Dun & Bradstreet No. (DUNS) or CAGE Code
Under what other names has your company operated?		

Indicate the geographic area where you have performed work within the last three (3) years.

Year 1	
Year 2	
Year 3	

Years in Business under present name:

Gross Sales for this year: \$  Gross Sales for last year: \$

Dollar Value of largest single project: \$

Name of present Surety:  Present Bonding Capacity: \$

Has this organization or any of its Officers been adjudged Bankrupt, subject to a receivership, or an Order of Re-Organization: ☐ Yes ☐ No

Name(s) of Principal Owners & Officers	Title/ Position

Please indicate the trade(s) that your company is interested in bidding:


Please indicate if your business is qualified as one or more of the following enterprise categories:

Are you a Small Business Enterprise?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you a Disadvantaged Business Enterprise?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you a Minority Business Enterprise?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you a Women Business Enterprise?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you a Veteran-Owned or Disabled Veteran-Owned Business ?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you a Lesbian, Gay, Bisexual, or Transgender Owned Business?	Y <input type="checkbox"/>	N <input type="checkbox"/>

Please include the following information with your application:

1. Attach a list of the five (5) largest contracts your organization has completed in the last three (3) years. (Please include the project name, client contact, contact phone number, A/E contract amount, and the completion date.)
2. Attach a list of your five (5) largest current contracts. (Please include the project name, client contact, contact phone number, A/E contract amount, and the completion date.)
3. If your business is qualified as one or more of the following enterprise categories, please include all applicable and current enterprise certificate(s):
  - a. Small Business Enterprise (SBE)
  - b. Disadvantaged Business Enterprise (DBE)
  - c. Woman-Owned Business Enterprise (SWBE)
  - d. Minority-Owned Business Enterprise (MBE)
  - e. Small HUBZone Business
  - f. Small Veteran Owned Business (SVOB)
  - g. Small Service-Disabled Veteran Owned Business (SDVOB)
  - h. Lesbian, Gay, Bisexual, or Transgender Owned Business (LBGT)
4. Please feel free to also include any supplemental qualification material or brochure in your response.

I certify that the information given herein is true and complete:

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please return the completed form and all attachments to [quals@torcon.com](mailto:quals@torcon.com).**

# Prequalification Contractor Safety Questionnaire

## COMPANY DETAILS

Company Name		
Telephone	Fax	Email Address
Street Address		
City	State	Zip
Contact Person	Address of Parent Company	
Insurance Carrier		

## SAFETY PERFORMANCE HISTORY

List your firm's Interstate Experience Modification Rate (EMR) for the last three years and use data from your OSHA 300 Logs to fill-in the appropriate data below as it relates to injuries and illnesses. If Interstate EMR is unavailable, the state EMR will be accepted.

	<u>2023</u>	<u>2022</u>	<u>2021</u>
Experience Modification Rate (EMR*)			
Number of Deaths (OSHA 300 Column G)			
Number of Cases with Days Away from Work (OSHA 300 Column H)			
Number of Cases with Job Restrictions (OSHA 300 Column I)			
Number of Cases Without lost days or time from work (OSHA 300 Column J)			
Number of Days Away from Work (OSHA 300 Column K)			
Number of Days at Work with Restrictions (OSHA 300 Column L)			
Number of Injuries (OSHA 300 Column M1)			
Number of Illnesses (OSHA 300 Column M2-5)			
Number of man-hours worked each year			
*Submit EMR verification forms & copies of the OSHA 300 Logs for the above noted years. Also provide a description of any work fatalities listed above.			
Has your company received any penalties from OSHA, EPA, DEP or any other government agency in the last three years? <i><b>If yes, please submit copies of the penalties</b></i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has your company received any safety awards in the last three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<i><b>If yes, please describe:</b></i>			

<b>SAFETY &amp; HEALTH PROGRAMS AND POLICIES</b>	
Does your firm have a written program that addresses the hazards that your employees are most typically exposed to? <i>If yes, please submit a copy</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who conducts the hazard program? Name: _____ Title: _____	
Does your company have a written hazard communication program? <i>If yes, please submit a copy</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your company developed any site-specific policy and procedure manual? <i>If yes, please submit a copy for review</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Safety Meetings</b>	
Does your company hold Site Safety Meetings or Tool Box Talks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who conducts these meetings? Name: _____ Title: _____	
How often are these meetings held?	
Are Safety Meetings held for Supervisors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how often are these meetings held?	
<b>Safety Audits/Inspections</b>	
Does your company have a safety audit/inspection program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who conducts the audits/inspections? Name: _____ Title: _____	
If yes, how often are audits/inspections conducted?	
If yes, are inspection forms reviewed by company management?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who reviews the inspection forms? Name: _____ Title: _____	
<b>Accident/Incident Investigations</b>	
On an attached sheet, please describe your accident investigation program.	
Does your company complete an accident report for all injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your company complete an accident report for all illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your company complete a report for near misses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your company complete a report for all incidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who conducts accident investigations? Name: _____ Title: _____	
Does Management review accidents reports?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who reviews the accident reports? Name: _____ Title: _____	
If yes, how often?	
<b>Training</b>	
Does your company have a safety and health training program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who conducts the training? Name: _____ Title: _____	

<b>SAFETY PERFORMANCE HISTORY</b>		
Does your company have a foreman/supervisors training program?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does it include instruction in the following areas?		
New Work Orientation		<input type="checkbox"/> Yes <input type="checkbox"/> No
First Aid		<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Response Procedures		<input type="checkbox"/> Yes <input type="checkbox"/> No
Accident Investigation		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hazard Communication		<input type="checkbox"/> Yes <input type="checkbox"/> No
Fire Protection & Prevention		<input type="checkbox"/> Yes <input type="checkbox"/> No
Conducting Craft Safety Meetings		<input type="checkbox"/> Yes <input type="checkbox"/> No
Safe Work Practices		<input type="checkbox"/> Yes <input type="checkbox"/> No
Process Safety Management Requirements		<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any other topics that are instructed in the foreman/supervisors training program:		
Does your company utilize an orientation program for new employees?		<input type="checkbox"/> Yes <input type="checkbox"/> No