



AN **ABEL** FAMILY OF BUSINESSES

Attachment "B"

Subcontractor Qualification Statement

Section 1 - General Information

Company Name _____
Address _____
City, State, Zip _____
Telephone # _____ Fax # _____
Tax ID # _____
Primary Contact Name _____
Contact Telephone #/email _____

Company Status:
UNION Yes ___ No ___ Both ___
Minority Owned _____ Woman Owned _____ Veteran Owned _____
Small Business _____ Hub Zone _____ Disadvantaged _____

Safety Information

Workers Comp EMR: - provide letter from Carrier verifying your Company's EMR

20__ : _____ 20__ : _____ 20__ : _____ Current _____

This section must be completed using the OSHA 300 form (last 3 years)

	20__	20__	20__
# OSHA Recordables	_____	_____	_____
Recordable Rate	_____	_____	_____
Lost Workday Case Rate	_____	_____	_____
DART Work Rate (day away restricted time)	_____	_____	_____
Fatalities	_____	_____	_____
OSHA Citations	_____	_____	_____
Total manhours worked	_____	_____	_____
Average # of Employees	_____	_____	_____

Does your company maintain/implement the following:

Written Safety Policy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Drug Free Workplace Policy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Conduct Safety Inspections	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Investigate Incidences, Injuries & Near Misses	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Occupational Healthcare provider	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Full Time Safety Director	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If yes, please provide name and contact information for Safety Director

By entering your name below, I hereby certify the about information is accurate, correct and true

Completed By _____
Title _____ Date _____

Rev: 06/18/19

QA-8030

**** company use****

reviewed by _____

Approved: Y ___ N ___