



Appendix A Contractor EHS Evaluation Package

This may only be used as approved by Risk Management and Safety (RMS) for small companies (e.g., less than 10 employees) and if they are the sole provider of the service. Please complete each Section and forward this form to your ND Representative who will then engage with RMS.

I. Company Information

Contractor	Parent Company (if applicable)
Name	Name
Home Office Address	Home Office Address
City, State, Zip Code	City, State, Zip Code
Phone	Phone

Individual Completing Form: _____

Title: _____

Phone Number: _____

Your classification for work: Prime Contractor Subcontractor

Name of your University Representative:

1. Do you certify that your employees and other individuals (subcontracted labor, temps, etc.) hired by your company to work at University are: Drug and alcohol free? **Yes**
No
2. Who is responsible for safety at your company?
Name: _____
Title: _____
Phone #: _____
3. Do you hire a safety consultant or firm to provide services? **Yes** **No**
If yes, continue below:
a. What is the contact information of the consultant or consulting firm?
Name: _____
Phone #: _____
4. Will all of the work at the University be self-performed by your own employees?
Yes **No** - explain or list the type(s) of work that will be subcontracted.
a. Do you have a procedure for evaluating the HS&E performance of sub-contractors prior to hire?
No Yes – Describe:



II. STATISTICS and INFORMATION – Questions 1-4 pertain to the past twelve (12) months

1. How many full-time employees were employed at your company? _____
2. How many part-time or temporary employees were employed at your company? _____
3. Did OSHA inspect any of your job sites? **No Yes**
 If YES, were you cited for any violations? **No Yes** - attach or provide details below:
 (Details may be provided on a separate sheet)
4. What is your current Worker's Compensation Experience Modification Rate (EMR)?

5. Did your company maintain an OSHA 300 Log for this year and the previous year? **No Yes**

Complete the information below or attached OSHA Form 300A for the previous 2 years.

STATISTICS From OSHA 300 Log	Current Year Year: _____	Previous Year Year: _____
Column G. # (Number) of Deaths		
Column H. # of injuries / illnesses with days away from work		
Column I. # of injuries / illnesses resulting in a job transfer or restriction		
Column J. # of other recordable cases		
Total Number of Hours Worked		
Injury/Illness Rate (IIR) <i>IIR=(200,000 x [Columns G+H+I+J])/Total Hours Worked</i>		

IV. CERTIFICATION – By Authorized Company Representative

I hereby certify that all information provided herein is accurate and correct.

Representative Name (Printed):

Representative Signature:

Title:

_____ Date: _____