



A  QUANTA SERVICES COMPANY

Sub-Contractor Prequalification

A. General Information

Business Name:

P.O. Box:

Street Address:

City:

State:

Zip Code:

Telephone:

Fax:

E-Mail:

What is your company's SIC Code?

NAICS Code?

2. **Does your company have branch offices in other areas?** Yes No

3. **Work Classifications of Sub-Contractor:** *Please list types of work you would like to perform as a sub-contractor for M.G. Dyess, Inc.*

B. Safety and Environmental Information

1. **Does your company have a Safety Program?** Yes No
If yes, please provide a Table of Contents

2. **Does your company have an Environmental Program?** Yes No
If yes, please provide a Table of Contents

3. **Does your company have an Employee Policy Manual?** Yes No
If yes, please provide a Table of Contents

4. **Does your company employ a full time EHS Director/officer?** Yes No

C. Employee Training Programs

1. **Does your company require Safety Training for your employees?** Yes No
If yes, please provide an outline of your companies training requirements.
2. **Does your company require Environmental Training for your employees?** Yes No
If yes, please provide an outline of your companies training requirements.
3. **Does your company require Equipment Operator training for your employees?** Yes No
If yes, please provide an outline of your companies training requirements.

D. Safety Statistics (Guidance Attached)

A.	Year: Please list information for three previous years	20	20	20
B.	Average Number of Employees:			
C.	Total Employee Hours Worked:			
D.	TRIR - Total Recordable Incident Rate:			
E.	DART Rate – Days Away/Restricted or Job Transfer Rate :			
F.	OSHA Citations			
G.	EPA Citations			
H.	Number of Fatalities:			
I.	Experience Modification Rating (EMR)			

If your company received any citations or been convicted of violations of OSHA or EPA regulations related to your subcontracted work in the last three (3) years, please attach a summary of the citation and/or conviction disposition.

E. Control of Alcohol, Illegal Drugs

1. **Does your company maintain an acceptable DOT Anti-drug and Alcohol Program?** Yes No
If yes, please provide a Table of Contents
2. **Does your company maintain an acceptable Non-DOT Anti-drug and Alcohol Program?** Yes No
If yes, please provide a Table of Contents

F. Operator Qualification (OQ)

1. **Does your company maintain an acceptable DOT Operator Qualification Program?** Yes No
If yes, which OQ group(s) are you affiliated with?
 - A. NCCER Yes No
 - B. OQSG Yes No
 - C. Veriforce Yes No
 - D. E-Web OQ Yes No
 - E. Other:

HAVE YOU INCLUDED THE FOLLOWING ATTACHMENTS WITH YOUR PACKAGE?

- | | | | | |
|---|--------------------------|-----|--------------------------|-----|
| 1. Safety Program Table of Contents | <input type="checkbox"/> | Yes | <input type="checkbox"/> | N/A |
| 2. Environmental Program Table of Contents | <input type="checkbox"/> | Yes | <input type="checkbox"/> | N/A |
| 3. Information verifying your EMR | <input type="checkbox"/> | Yes | <input type="checkbox"/> | N/A |
| 4. Outline of your equipment operator training requirements | <input type="checkbox"/> | Yes | <input type="checkbox"/> | N/A |
| 5. Table of contents of your D/A plan | <input type="checkbox"/> | Yes | <input type="checkbox"/> | N/A |

G. Sub-Contractor Prequalification Completed By:

By signing below, the undersigned certifies:

- That he or she is authorized to execute this questionnaire and provide foregoing information.
- That he or she has reviewed the information provided above and that the information is true and accurate as of the date indicated below.

Name: _____ **Signature:** _____

Title: _____ **Date:** _____

H. M.G. Dyess, Inc. Approval:

Approved: Yes No **Approved Conditional:** Yes No

Explain Decision:

Name

Date

Signature

Title

Section D - Safety Statistics Guidance:

A. Year: List the three most recent calendar years

B. Average Number of Employees: List the average number of employees who worked during the year. An employee shall be defined as any person who engaged in activities for an employer from whom direct payment for services is received. Include working owners and officers. This number may be obtained by dividing the total number of payroll checks written in a given year by the total number of pay periods in a given year.

C. Total Employee Hours Worked: List the total number of hours worked during the year by all employees, including those in operating, production, maintenance, transportation, clerical, administrative, sales, and other activities.

D. TRIR – Total Recordable Incident Rate: Insert the Total Recordable Incident Rate for incidents and illnesses that occurred in that year. Recordable cases include all work-related injury or illness cases. These include all incidents resulting in medical treatment beyond first aid including, but not limited to - days away from work, restricted work activity, and incidents causing temporary or permanent job transfer.

TRIR equals The total number of Recordable Cases multiplied by 200,000 divided by the total annual man-hours

E. DART Rate – Days Away/Restricted or Job Transfer Rate: The total number of recordable cases that required days away from work, restricted duty, or job transfer. Any incident requiring a health care professional to assign an employee restricted duty or a day or more away from work other than the day of the injury/illness is considered a DART Case.

DART Rate equals the number of DART Incidents multiplied by 200,000 divided by the total annual man-hours.

F. OSHA Citations – Total number of violations cited by OSHA in the past three years

G. EPA Citations – Total number of violations cited by EPA in the past three years

H. Number of Fatalities: Total number of job related fatalities as defined by OSHA for each listed year.

I. Experience Modification Rating: We require verification for the EMR and discount rate. A letter from your insurance agent, insurance carrier, state fund (on the supporting entities letterhead) or an identifiable NCCI document bearing the information will meet this requirement.