SUBCONTRACTOR PRE-QUALIFICATION FORM

You must complete all the required fields (\*) before submitting this application. Please Don't use single colons ( ' ) on the Form. NOTE: In order to use this Form JavaScript must be Enabled on your Browser.

Top of Form

Date:

## COMPANY INFORMATION

1. Company Name: \*

2. Phone Number: \*

3. Contact Name: \*

4. Contact Title: \*

5. Mailing Address: \*

6. Headquarters Address: \*

6.A. Email \* 

7. Other branch addresses if applicable:

8. Tax ID # / FEIN: \*

9. D&B #:

10. How many years has your company been in operation? \*

11. Please specify type of business entity (i.e. Corporation, Limited Liability Company or other): \*

If a Corporation, please mention State of Incorporation:

12. Does your company operate under any other business name currently or in the past? \*

13. Is your Firm Affiliated with any other company? \*

Firm Name:

Phone:

Address:



If yes, please list all applicable names below:

Other Company Names:

14. Has your firm done business with 3MB before under current or any other name? If yes, please list all applicable names below: \*

15. Current number of payroll employees:

16. Is your labor force part of a union? \*

If yes, mention what union (s):

17. Does your company have a Minority/Small Business Status? \*

## FINANCIAL DATA

1. Indicate the highest subcontract value your firm wishes to be considered for:

Please Note: Contractor must be able to bond amount of contract considered below.

2. Name of Surety?

Bonding Agent:

Phone:

Address:



a. Maximum Bonding capacity for single job?

b. Total bonding capacity?

Do you have insurance? If yes, please provide coverage type:

3. Total value of active Contracts?

4. Average (latest three years) yearly volume of work completed in dollars.

|  |  |  |
| --- | --- | --- |
| YEAR |  | AVG $ VOLUME |
|  |  |  |
|  |  |  |
|  |  |  |

## SAFETY RECORD AND PROGRAM (EMR-experience Modification Rate)

|  |  |  |
| --- | --- | --- |
| YEAR |  | EMR |
|  | = |  |
|  | = |  |
|  | = |  |
|  | = |  |
|  | = |  |

2. Number of employee hours worked (Do not include any non-work time even if paid.) (SRP HRS)







3. Please, calculate incidence rate (I.R) for each year for each year record able and lost time accidents using the following formula:

N= Number of cases from OSHA Log N x 200,000  
Employee Hours Worked (given year) = I.R.



4. Do you have a safety officer/department in your company?

5. Do you have a written safety program?

If the answer is yes, make program available for inspection upon request.

6. Do you have a drug and alcohol policy?

If the answer is yes, make program available for inspection upon request.

7. Do you have in place a safety orientation program for new employees?

If the answer is yes, make program available for inspection upon request.

ALL INFORMATION SUBMITTED IS HELD IN STRICT CONFIDENCE. BY CLICKING IN THE BOX YOU HEREBY CERTIFY THAT ALL THE FOREGOING STATEMENTS CONTAINED HEREIN ARE TRUE AND CORRECT.

AUTHORIZED SIGNATURE: \*

Please provide authorized full name

Contact Title: \*

Date: \*

YearMonth Day