



SUBCONTRACTOR PREQUALIFICATION APPLICATION

GENERAL INFORMATION

Company name:		Date of Response:	
Phone:	Fax:	E-mail:	
Main office address:			
City:		State:	ZIP Code:
Website:			
Sole proprietorship:	Partnership:	Corporation:	Other:
Year Company Started:		State of Inc.:	Date of Inc.:

MAIN OFFICE CONTACTS

Contact Info:		
Name:	Phone:	Fax:
Cell:	Email:	
Name:	Phone:	Fax:
Cell:	Email:	

CORPORATE OFFICERS

Name:	Phone:
Position:	Fax:
Percent Owned:	Email:
Name:	Phone:
Position:	Fax:
Percent Owned:	Email:

GEOGRAPHIC WORK AREAS – LOCAL AREA NAME

WORK SCOPE

Please list primary CSI codes:

1.
2.
3.
4.



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SAFETY INFORMATION

Current EMR Rates

2007:	Rate:
2006:	Rate:
2005:	Rate:

OSHA 30 Certified Personnel

Name:	Phone:	Email:
Name:	Phone:	Email:
Name:	Phone:	Email:

OSHA 200/300 Information

2007 Reporting Year

Number of Fatalities:	Description:
Number of lost and restricted workday cases:	Employee hours worked:
How many OSHA violations has this company received this year?	
If these violations were willful please provide a description:	
Recordable incidence rate:	Lost workday incidence rate:

2006 Reporting Year

Number of Fatalities:	Description:
Number of lost and restricted workday cases:	Employee hours worked:
How many OSHA violations has this company received this year?	
If these violations were willful please provide a description:	
Recordable incidence rate:	Lost workday incidence rate:

2005 Reporting Year

Number of Fatalities:	Description:
Number of lost and restricted workday cases:	Employee hours worked:
How many OSHA violations has this company received this year?	
If these violations were willful please provide a description:	
Recordable incidence rate:	Lost workday incidence rate:



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SAFETY QUESTIONNAIRE

Does your company have a qualified person responsible for safety within your Company?	YES	NO
If yes, please describe his/her qualifications:		
Does this person do safety inspections on all of your projects?	YES	NO
If yes, how often are these inspections?	DAILY	WEEKLY
	MONTHLY	QUARTERLY
	YEARLY	
Has your company ever implemented 100% fall protection?	YES	NO
If requested can you provide us with a sit-specific program addressing the fall hazards in your company's work?	YES	NO
Does your company have a written Company Safety Policy and Program and will you provide copies if requested?	YES	NO
Does your company require documented safety meetings for your employees? Indicate how often:	DAILY	WEEKLY
	MONTHLY	QUARTERLY
	YEARLY	
Does your company provide safety training for all employees? If yes, describe training provided:	YES	NO
Does your company set annual safety training goals?	YES	NO
If yes, please list examples of training goals:		
Does your company have a program recognizing your employees for safety excellence?	YES	NO
Does your company have a disciplinary program in place for safety violations?	YES	NO
Does your company conduct accident/incident investigations?		
Does your company review the safety management system of your sub-contractors?	YES	NO
Does your company conduct accident/incident investigations?	YES	NO
Does your company have a substance abuse policy?	YES	NO
If yes, please indicate which are included in your policy:		
Pre-hire/Initial Employment	YES	NO
Cause	YES	NO
Post Accident/Incident	YES	NO
Random	YES	NO
Periodic	YES	NO
Does your company have a return to work/light duty program?	YES	NO
If yes, provide work/light duty program description:		



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GENERAL FINANCIAL INFORMATION

Federal tax identifier number:

Contractor License Information

State:	Number:	Expiration:
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Largest Contract Completed

Name:	Year:	Amount:	Scope:
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Largest dollar volume your company expects to do during this year

Name:	Year:	Amount:	Scope:
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Expected annual volume this year

Amount:	Number of projects:
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Percent of work normally subcontracted: %

Average annual volume of work performed over the past five years

2007 Average volume:

2006 Average volume:

2005 Average volume:

Banking General Information

Bank Name:

UCC Filing:	Credit Secured By:
D&B Number:	D&B Rating:
Pay Record:	Date of Rating:

Remarks:

Banking Contact Information

Contact Name:

Address:	City:
State:	Zip:

Phone:	Fax:	Email:
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Major Supplier Contact Information

Company Name:		Contact Name:	
Street:		City:	
State:		Zip:	
Phone:	Fax:	Email:	

Contractor Contact Information for Company Name

Company Name:		Contact Name:	
Street:		City:	
State:		Zip:	
Phone:	Fax:	Email:	

LEGAL INFORMATION

Has your company or any of its principals ever petitioned for bankruptcy, failed in business, defaulted or been terminated on a contract awarded to you? YES NO

Explanation:

Have any of the Owners, officers or major stockholders of your Company ever been indicted or convicted of any felony or other criminal conduct? YES NO

Explanation:

Has your Company ever been disbarred or otherwise precluded from pursuing public work or ever been found to be non-responsive by a public agency? YES NO

Explanation:

Has your Company ever had a claim made against it for improper, delayed, defective or non-compliant work or failure to meet warranty obligations? YES NO

Explanation:

Is your Company or any of its owners, officers or major shareholders currently involved in any arbitration or litigation? YES NO

Does your Company have any outstanding judgments or claims against it? YES NO

Explanation:

Please list any litigation brought against your Company in the past five years asserting that you failed to make payment to anyone.

BONDING / SURETY INFORMATION

Surety Company Name:		Surety Broker Name:	
Bonding Capacity Per Job: \$		Aggregate: \$	
Date of Last Bond:		Bond Rate:	

Please list the persons or entities who provide indemnification to your surety:

Contact Name:			
Street:		City:	
State:		Zip:	
Phone:	Fax:	Email:	



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INSURANCE INFORMATION

Insurance Carrier:	Policy number:
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Commercial General Liability Information

General Aggregate: \$	Personal/Adv. Injury: \$
Each Occurrence: \$	Fire Damage: \$
Medical Expenses: \$	Deductible: \$

Excess Liability Information

Umbrella Limit: \$	
General Aggregate:\$	Each Occurrence:\$

Workers Compensation and Employer's Liability Information

Each Accident:

Automobile Liability

Combined Single Limit: \$	Bodily Injury(per person): \$
Bodily Injury (per accident): \$	Property Damage: \$

Insurance Contact Information

Contact Name:	
Street:	City:
State:	Zip:



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SIGNATURE PAGE

We have attempted to answer all questions in a full and complete manner to assure that our answers are not in any respect misleading, either by expressing ourselves in a misleading or ambiguous manner or omitting information. We recognize that HGC will be relying on the accuracy of the information and our responses in this questionnaire in deciding whether to permit us to bid and in awarding work to our Company.

Name of Company:

Completed by:

Title:

Date:

Subscribed and sworn before me this day of day of Two Thousand and

Notary Public:

My commission expires: