



CONTRACTOR SAFETY QUALIFICATION PACKET

DOCUMENT NO.: **F640D18**
REVISION: **D**
EFFECTIVE DATE: **12/12/12**
PROCESS OWNER: **Larry Lopez**

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COMPANY DATA

1. **Company Name:** _____

Subsidiary/Division of: _____

Local Address: _____

Headquarters Address: _____
(If different from local)

2. **Contact Name/Title:** _____

Telephone No.: _____

Email Address: _____

FAX No.: _____

Local Address: _____

3. **Form of Company Ownership:** Sole Proprietorship
 Partnership
 Corporation State: _____

Date Company Established: _____

Name or Names Company Has Previously Operated Under:

4. **Total No. of Employees:** _____



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COMPANY HISTORY

1. Job History With Santa Clara Valley Water District (Give date and brief description for past three years):

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2. Please provide references for your last three jobs of similar type and scope as the work proposed by Santa Clara Valley Water District:

	COMPANY	CONTACT	PHONE NO.
1)			
2)			
3)			

Briefly describe the type and scope of work performed:

- 1) _____
- 2) _____
- 3) _____

WORK TO BE PERFORMED

1. Briefly describe the type and scope of work to be performed:

- 1) _____
- 2) _____
- 3) _____

2. Identify any hazardous work activities to be performed (confined space, hot work, lockout/tagout, etc.):

3. Will contractors be exposed to hazardous materials/waste (asbestos, lead, mercury, etc.)? Yes No

4. Identify work location(s): _____

5. Identify SCVWD Project Manager: _____

6. Identify expected start and end dates: _____

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**SECTION A. WORKERS' COMPENSATION INSURANCE—
EXPERIENCE MODIFICATION RATE (EMR)**

- 1. Please obtain from your insurance agent/broker/carrier your intrastate EMRs for the last three rating periods. If you do not have an intrastate rating, obtain your interstate EMRs. Then complete the following data and check the appropriate box for intrastate or interstate EMR.**

	POLICY YEAR	MODIFICATION RATE
Current EMR		
1 Year Ago		
2 Years Ago		
Rating Type: <input type="checkbox"/> Intrastate <input type="checkbox"/> Interstate		
By initialing here, I certify that this company does not have an EMR: _____ (You must submit a copy of your company's Loss Runs for the last three years if your company does not have an EMR.)		
Is your company self-insured for Workers' Compensation Claims? <input type="checkbox"/> Yes. If yes, please attach a copy of the latest Annual Report to the State of California Department of Industrial Relations and/or State of California Certificate of Self-Insurance. <input type="checkbox"/> No		

2. Anniversary Rating Date: _____ **Rating Bureau File No.:** _____

3. Name of Your Company's Workers' Compensation Carrier: _____

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SECTION B. OSHA/LOST WORKDAY INCIDENCE RATES

To answer the following questions, utilize data obtained from your company’s OSHA 300 “Log and Summary of Occupational Injuries and Illnesses,” or Workers’ Compensation Loss Run (if your company has 10 or fewer employees).

ALL COMPANIES HAVE DATA TO REPORT, AND MUST COMPLETE THIS SECTION.

1. **Record your Industry Comparison Information number (NAICS Code):** _____
 (The North American Industry Classification System [NAICS] has replaced the U.S. Standard Industrial Classification [SIC] system.) **Provide data only for the years identified below.** <http://www.naics.com/search.htm>

2. **What was your company-wide OSHA Total Case Incident Rate* (recordable cases) for the last three years?**

YEAR	NO. OF CASES	CO. HOURS ***	RATE
2009			
2010			
2011			

3. **What was your company-wide Lost Workday Case Incidence Rate** (recordable cases with lost workdays or restricted duty) for the last three years?**

YEAR	NO. OF CASES	CO. HOURS ***	RATE
2009			
2010			
2011			

INFORMATION TO AID IN COMPLETING SECTION B. 2 AND 3:

* OSHA Total Case Incidence Rate =
$$\frac{\text{Total No. of Recordable Cases} \times 200,000}{\text{Company Man-Hours}}$$

** Lost Workday Case Incidence Rate: =
$$\frac{\text{No. of Lost Workday Cases} \times 200,000}{\text{Company Man-Hours}}$$

*** Co. Hours = Hours worked by all employees on the Company payroll in the applicable calendar year.

- Do not use the number of lost workdays in these three calculations.
- Rates are not a “%,” nor should the number be similar to “0.00024.”
- To verify your calculations for a given year, check your math as follows:
 Lost Workday Case Rate + No Lost Workday Case Rate = Total Case Incidence Rate



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SECTION C. OSHA CITATION (VIOLATION) HISTORY

Has your company received any “serious,” “willful,” “repeat,” or “failure to abate” OSHA violations (citations) within the past sixty (60) months, beginning immediately prior to submittal of this questionnaire? This question **includes** such citations if they have been appealed or contested, but have not yet been resolved. If yes, check “Yes” below and submit copies of all citations and descriptions of abatement actions, your company Injury and Illness Prevention Program and Code of Safe Practices, **and** your OSHA 300 Log and Summaries for each of the last three years. Provide a completed OSHA form 160 or 161 for each citation identified.

- Yes. If yes, list total number of citations (violations) by type per year in the table below.
- No.

YEAR	SERIOUS	WILLFUL	REPEAT	FAILURE TO ABATE	TOTAL

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**SECTION D. SAFETY POLICIES AND PROCEDURES
(18 QUESTIONS)**

No.	QUESTIONS	YES	NO	POINTS
1.	Injury and Illness Prevention Program. Does your company have an effective, written Injury and Illness Prevention Program (IIPP) in accordance with 8CCR §1509 and §3203? [LC §6401.7]	<input type="checkbox"/>	<input type="checkbox"/>	20
2.	Does your company have a safety policy statement endorsed by top management? [LC §6401]	<input type="checkbox"/>	<input type="checkbox"/>	2
3.	Does your on-site safety representative have sufficient authority to implement changes and implement corrective action? [LC §6401.7(a)(7)]	<input type="checkbox"/>	<input type="checkbox"/>	2
4.	Does your company have a disciplinary action program that includes provisions for acting on safety and health issues of your employees (and subcontractors, if applicable), and is the program enforced? [LC §6401.7(a)(6)]	<input type="checkbox"/>	<input type="checkbox"/>	2
5.	Does your company have a safety incentive program effective in reducing occupational injuries and illnesses? [8 CCR §3203(a)(2)]	<input type="checkbox"/>	<input type="checkbox"/>	2
6.	Do your company safety and health policies, procedures, and subcontract agreements address minimum safety requirements in accordance with OSHA and Owner requirements for suppliers, and vendors and subcontractors? [LC §6401.7(h)]	<input type="checkbox"/>	<input type="checkbox"/>	4
7.	Does your company have a comprehensive Hazard Communication Program that (a) details locations for Material Safety Data Sheets (MSDS) and (b) contains provisions for multi-employer job sites? [8 CCR §5194]	<input type="checkbox"/>	<input type="checkbox"/>	10
8.	Do you conduct ongoing job site safety and health inspections, and are the inspection records kept on file and available for review? [LC §6401.7(A)(2)]	<input type="checkbox"/>	<input type="checkbox"/>	12
9.	Are the inspection records and written evidence that safety and health concerns have been reviewed and corrective action taken maintained and available for review? [LC§6401.7(b) and (D)]	<input type="checkbox"/>	<input type="checkbox"/>	4
10.	Safety Reviews/Hazard Analysis. Are all critical (hazardous) job activities identified and Job Safety Analysis' (JSA, a.k.a. Job Hazard Analysis, or JHA) conducted by your company (and subcontractors, if applicable)? [LC§6401.7(A)(5)]	<input type="checkbox"/>	<input type="checkbox"/>	6
11.	Are the procedures for critical (hazardous) job activities written and reviewed with all employees (including subcontractor employees)? [LC 6401.7(a)(5)]	<input type="checkbox"/>	<input type="checkbox"/>	2

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No.	QUESTIONS	YES	NO	POINTS
12.	Accident/Incident Investigation and Analysis. Does your company have a written accident/incident investigation procedure in which: (a) all accidents/incidents (including those of subcontractors, if applicable) are investigated to determine their root cause, and (b) corrective action is taken by site supervision and management, and (c) written investigation and corrective action records are available for review? [8CCR §3203(a)(5) and (b)]	<input type="checkbox"/>	<input type="checkbox"/>	4
13.	Are reports completed for "near miss" incidents that might have caused serious injury, property, or equipment damage? [LC §6403(b)]	<input type="checkbox"/>	<input type="checkbox"/>	2
14.	Emergency Response. Does your company have a comprehensive written emergency response plan (i.e., fire, toxic spills, bomb threats, natural disasters, crowd and traffic control, and media relations) for job sites; and do all employees (including subcontractor employees, if applicable) receive project-specific emergency response training? [8 CCR §3220(a) and (e)]	<input type="checkbox"/>	<input type="checkbox"/>	4
15.	Substance Abuse Control Program. Does your company have a written Substance Abuse Program? [LC §6403]	<input type="checkbox"/>	<input type="checkbox"/>	2
16.	Do you require your subcontractors of all tiers to have a Substance Abuse Program? [LC §6403]	<input type="checkbox"/>	<input type="checkbox"/>	2
17.	Employee Training. Does your company ensure that all employees (including subcontractor employees) are trained in accordance with your company's written training plan, and (a) are competent to perform the work required, and (b) that job tasks requiring specific training and/or certification are performed by employees having the appropriate training documentation and certificates, and the documentation is maintained and available for review? [LC §6401.7(c) and (d)]	<input type="checkbox"/>	<input type="checkbox"/>	10
18.	Is documentation on file and available for review to verify that training and safety meetings for your company (and subcontractors, if applicable) have been completed? [LC §6401.7(c) and 8CCR §1509(e)]	<input type="checkbox"/>	<input type="checkbox"/>	10



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CONTRACTOR CERTIFICATION STATEMENT

NOTE: The Santa Clara Valley Water District reserves the right to request any and all documentation necessary to verify responses submitted in Sections A, B, C, and D of this Contractor Safety Qualification Packet.

I certify that the information contained herein is true and correct to the best of my knowledge and that no attempt has been made to give false, omissive, or misleading information. I further certify that I shall comply with the safety qualification requirements for any and all subcontractors my company shall employ for any Santa Clara Valley Water District project and I certify under penalty of perjury under the laws of the State of California that these subcontractors meet the safety standards and all other Santa Clara Valley Water District requirements prior to contracting with them for use on any Santa Clara Valley Water District project.

If sending the document via e-mail, fill in the "Printed/Typed" line with the name of the authorized agent for the company. The document is considered signed and valid if transmitted via the signatories e-mail address.

Signed: _____

Printed/Typed: _____

Title: _____

Date: _____