

# SAFETY RECORD FORM

## I. General Information

Name of Firm:	
Business Address:	
Telephone:	Fax:
Prepared by/Title:	Date prepared:

## II. Experience Modification Rates

- A. List your firm's Workers Compensation Experience Modification Rates (EMR) for the last three years.

Year	Experience Modification Rate (EMR)

## III. OSHA Incidence Rates

- A. List your firm's Occupational Safety Health Administration (OSHA) total recordable incidence rates for the last three years.

Year	Total Recordable Incidents	Total Hours Worked	OSHA Incidence Rate*

\* Use your OSHA Form No. 200 and the formula:

$$(\text{Total Incidents} \times 200,000 \text{ hours}) \div (\text{Number of hours worked}) = \text{Incidence Rate}$$

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### III. OSHA Incidence Rates (cont'd)

B. Provide your incidence rates over the last three years for the following categories:

Category	Incidence Rate by Year*		
	Year _____	Year _____	Year _____
Injuries and Illness with Lost Work Days			
Injuries and Illness with Job Transfer or Restricted Work Days			

\* Use your OSHA Form No. 200 and the formula:

$$(\text{Total Incidents} \times 200,000 \text{ hours}) \div (\text{Number of hours worked}) = \text{Incidence Rate}$$

C. Provide your incidences of fatality over the last five years:

Category	Fatalities by Year				
	Year _____	Year _____	Year _____	Year _____	Year _____
Number of Fatalities					

D. Does your firm have any upheld OSHA citations in the past five years?

Yes  No  (If yes, attach explanation)

### IV. Safety Program Information

A. Do you have a written safety program?

Yes  No  (If yes, attach outline)

B. Which of the following does your safety program contain:

1. Does your company require health and safety training of its subcontractors?

Yes  No

2. Is documentation of health and safety training required?

Yes  No

3. Do you have a Hazard Communication Program (29 CFR 1910.1200, CCR Title 8 Section 5194)?

Yes  No

4. Do you have a Confined Space Entry and Rescue Program (29 CFR 1910.146, CCR Title 8 Section 5156-5159)?

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Yes  No  (If yes, attach explanation)

5. Do you have a "Hot Work" permit program (29 CFR 1910.146, CCR Title 8 5156-5159)?

Yes  No  (If yes, attach explanation)

6. Do you have a "Lock-Out/Tag-Out" program (29 CFR 1910.417)?

Yes  No  (If yes, attach explanation)

*C. Do you have an Equipment Maintenance Program for the following:*

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Miscellaneous construction tools and equipment? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Ladders?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Scaffolds?                                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Heavy Equipment?                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Vehicles?                                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

*D. Do you have a new employee safety orientation program?*

Yes  No

1. If yes, does it include instruction in the following:

- |                                   |                              |                             |
|-----------------------------------|------------------------------|-----------------------------|
| (a) Company Safety Policy         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Company Safety Rules          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) Safety Meeting Attendance     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Company Safety Record         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Hazard Recognition            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (f) Hazard Reporting              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (g) Injury Reporting              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (h) Non-Injury Accident Reporting | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (i) Personal Protective Equipment | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (j) Respiratory Protection        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (k) Fire Protection               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (l) Housekeeping                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (m) Toxic Substance               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (n) Electrical Safety             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (o) Fall Protection               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (p) First-Aid/CPR                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (q) Driving Safety                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (r) Hearing Conservation          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (s) Lock-Out/Tag-Out              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (t) Bloodborne Pathogens          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (u) Asbestos                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (v) Confined Spaces               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (w) Hazard Communication          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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### IV. Safety Program Information (cont'd)

E. Do you conduct safety meetings for your employees? Yes  No

1. If yes, how often:

Daily  Weekly  Bi-weekly  Monthly  As Needed

F. Do you conduct health and safety audits of work in progress?

Yes  No

1. If yes, who conducts the audits?

\_\_\_\_\_

2. How often are the audits conducted?

\_\_\_\_\_

G. Do you notify all employees of accidents and precautions related to accidents and near misses?

Yes  No

1. If yes, how is this notification accomplished?

(a) Safety meetings	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(b) Post notification in office	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(c) Post notification at the site where the incident occurred	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(d) Other _____		

H. Is safety a criteria in evaluating the performance of:

1. Employees	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Supervisors	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Management	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I. Does your firm hold "tailgate" safety meetings? Yes  No

1. If yes, how often:

Daily  Weekly  Bi-weekly  Monthly  As Needed

J. Does your company have a drug and alcohol testing policy?

Yes  No

K. Does your company require that subcontractors participate in a drug surveillance/testing program?

Yes  No

L. Does your company have a method of disseminating safety information?

Yes  No