

Health & Safety Questionnaire

PREAMBLE			
<i>This information is to be used to determine the safety record. A poor safety record will be grounds to not pre-qualify any prospective contractor or sub-contractor.</i>			
CERTIFICATION			
The information provided in this questionnaire is an accurate summary of the Company's Health and Safety Management System:			
Company Name:			
Signed:		<i>(print name)</i>	
Position:		Date:	
1. SAFE WORK PERFORMANCE			
1A. Injury Experience / Historical Performance			
Use the previous three years injury and illness records to complete the following:			
Year			
Number of Fatalities			
Number of Medical Treatment cases			
Number of Restricted Work Day cases			
Number of Lost Time Injury cases			
Total Work Injuries			
Total Work Injury Frequency			
Lost Time Injury Frequency			
Total Recordable Frequency			
Number of Man-hours			
1 – Lost Time Cases (LTI)	Any occupational injury illness that prevents the worker from performing any work for at least one day not counting the day of the injury/illness		
2 – Restricted Work Day Case	Any occupational injury or illness that prevents a worker from performing any of his/her duties		
3 - Medical Treatment Case	Any occupational injury or illness requiring treatment beyond first aid		
4 – Total Work Injuries (TWI)	Total number of LTI's, MTI's and FAI's		
5 - Total Work Injury Frequency	Number of TWI's multiplied by 200,000 and divided by hours worked.		
6 - Lost Time Injury Frequency	Total number of Lost Time Injury cases multiplied by 200,000 then divide by total manhours		
7 – Total Recordable Frequency	Total number of 1, 2 and 3 cases multiplied by 200,000 divided by total manhours		
1B. Workers' Compensation Experience			
Industry Code.		Industry Classification:	
Year			
Experience Modification Rating			

2. Citations						
2A.	Has your company been cited, charged or prosecuted under Health, Safety and/or Environmental Legislation in the last 5 years? <i>If yes, provide details.</i>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
2B.	Has your company been cited, charged or prosecuted under the above Legislation in another Country, Region or State? <i>If yes, provide details.</i>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Safety Program						
3A	Do you have a written safety program manual? <i>If yes, provide a copy for review</i>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
3B	Do you have a pocket safety booklet for field distribution? <i>If yes, provide a copy</i>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Training Program						
4A	Is health and safety training conducted in your company?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
4B.	Do you have an orientation program for new hires employees?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
4C	Do you have a program for training newly hired or promoted supervisors?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. SAFETY ACTIVITIES						
5A	Do you conduct safety inspections? <i>If Yes, how often?</i>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly			
Who follows up on inspection action items?						
5B	Do you hold site safety meetings for field employees? <i>If Yes, how often?</i>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Biweekly			
5C	Do you hold site meetings where safety is addressed with management and field supervisors? <i>If Yes, how often?</i>				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Weekly	<input type="checkbox"/> Biweekly	<input type="checkbox"/> Monthly			
5D	Do you have a hazard assessment process?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
5E	Are hazard assessments documented?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
5F	Does your company have policies and procedures for environmental protection, spill clean-up, reporting, waste disposal, and recycling as part of the H&S Program?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
5G	Does your company set safety targets and objectives?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
5H	Does your company prepare and implement site-specific safety plans?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Safety Reporting						
6A	Are incident reports and report summaries sent to the following and how often?					
		Yes	No	Monthly	Quarterly	Annually
	Project/Site Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vice President/Managing Director	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Safety Director/Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	President/Chief Executive Officer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6B	How are incident records and summaries kept? How often are they reported internally?					
		Yes	No	Monthly	Quarterly	Annually
	Incidents totaled for the entire company	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Incidents totaled by project	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<ul style="list-style-type: none"> • Subtotaled by superintendent <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually • Subtotaled by foreman <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6C	Does your company track non-injury incidents?					
		Yes	No	Monthly	Quarterly	Annually
	Near Miss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Property Damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6D	Do you name the person(s) responsible for Safety on your projects?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Who has overall responsibility and accountability for safety on your projects?		

6E	Does senior management demonstrate commitment to your company's safety policy and management system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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7. Personnel		
List key health and safety professionals in the organization.		
Name	Position/Title	Designation