SUBCONTRACTOR’S SAFETY SURVEY

(Submit this form prior to work beginning)

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Safety Rep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide your Worker’s Compensation Experience Modification Rate (EMR) for the last 3 year:

|  |  |  |  |
| --- | --- | --- | --- |
|  **YEAR** |  2016  |  2017 |  2018 |
|  **EMR** |  |  |  |

Name of your Worker’s Compensation Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide the following data from your OSHA 300 logs for the last three years:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Year | Ave. # of Employees | Total Hours Worked | Cases – Days away from work (H) | Cases – Job Transfer or Restriction (I) | Other Recordables (J) | # of days Away from Work (K) | # of days Job Transfer or Restriction (L) |
| 2017 |  |  |  |  |  |  |  |
| 2016 |  |  |  |  |  |  |  |
| 2015 |  |  |  |  |  |  |  |

List any OSHA citations in the last 36 months:

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Violation(Code or CFR#) | Type(Serious, Willful, Repeat) | Describe |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If more than three citations, please contact Safety Director at Marion- 503-581-1920.

Please answer the following: Yes/No Describe/Explain

|  |  |  |
| --- | --- | --- |
| Do you have a Written Safety Manual? |  |  |
| Are all employees given safety training? |  |  |
| Do you conduct site inspections? |  |  |
| Do you discipline employees for violations? |  |  |
| Do you document all incidents and injuries? |  |  |
| Do you conduct post-incident investigations? |  |  |

Do you have established safety programs for all affected employees in the following areas:

 Yes/No If no, please explain

|  |  |  |
| --- | --- | --- |
| New Employee Safety Orientation |  |  |
| Drug and Alcohol-Free Workplace |  |  |
| Hazard Communication Program |  |  |
| Personal Protective Equipment Training |  |  |
| Active Safety Committee |  |  |
| Routine Safety Meetings – Tool Box Talks |  |  |
| Early Return-to-Work & Monitoring Days Away |  |  |
| Fall Protection, Ladders, Scaffolds Safety |  |  |
| Electrical, LOTO, Equipment Grounding |  |  |
| Construction Health: Noise, Dusts, etc |  |  |
| Excavation and-or Confined Spaces |  |  |
| Ergonomics, Back Safety |  |  |
| Traffic Control, Flagging, Work-Zone Safety |  |  |
| Equipment training and qualification |  |  |
| Material Handling, Rigging, Lifting |  |  |
| First Aid-CPR, Emergency Action Plans |  |  |

**SITE-SPECIFIC SAFETY PLAN**

Describe the primary type of work your company will perform for Marion Construction Co:

For each item of work performed, OSHA may require a written program. Does your company have written safety programs for each area where required? YES / NO

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_