SUBCONTRACTOR SAFETY PROGRAM EVALUATION

Company Name: ______________________________ Date: __________________

Fed Tax ID #: _____________________ Division/State/: __________________

Contractor UBI #: _____________________ SIC/NAICS Code: __________________

Please provide the following historical information for ☐Interstate or ☐Intrastate (____):

Information:	Years:	Current Year	Provide data for the previous three complete years 20___	20___	20___
Experience Modification Rate:					
Total Man Hours Worked:					
# of Lost Workday Cases: *(Column H from 300 Log)*					
# of Days Away *(Column K from 300 Log)*					
# of Restricted Duty Cases: *(Column I from 300 Log)*					
# of Days Restricted *(Column L from 300 Log)*					
# of Other Recordable Cases: *(Column J from 300 Log)*					
Total Recordable Cases: *(Columns H, I, & J, from 300 Log)*					
DART Severity Rate: *(Columns K & L from 300 Log*200,000/Hours)*					
Number of Fatalities:					
Number of Safety Related Citations:					
Number of Vehicle Accidents:					
Average Number of Employees *(From OSHA 300A)*					

Do you have a written safety & health policy? ☐ NO ☐ YES

Do you conduct drug & alcohol testing? ☐ NO ☐ YES

Do you provide training for employees? ☐ NO ☐ YES

Primary Workers Compensation Provider: ______________________________

Policy Number: ______________________________

Renewal Date: ______________________________

Person Responsible for Safety & Health: ______________________________

Title: ______________________________

Phone Number: ______________________________

Company Use Only							
3yr Ave.	EMR <1	DART <2	TRIR <3	Approved:	☐ YES	☐ NO	☐ COND
				By:			