|  |
| --- |
| Please complete this form and return it to the undersigned at your earliest convenience. This information will be kept on file and used to evaluate contractors for our various projects. |
| **SEND COMPLETED QUESTIONNAIRE TO:**mtm.procurement@nyrstar.com etm.procurement@nyrstar.com  |
| Obtain from your insurance agent (or state fund, if possible) your workers' compensation insurance experience modification rate (EMR) for the three most recent rating periods and complete the following: |
| **POLICY YEAR:** | **EMR:** | **If your EMR is exactly 1.0 for any policy year, is it because your firm is (or was) too new or too small to have an EMR calculated?** |
| Most recent policy year: |       |       |  |
| 1 year prior: |       |       |  |
| 2 years prior: |       |       | [ ]  YES | [ ]  NO |
| **We require verification of the above information. Any of the following methods will be acceptable:** |
| * Furnish a letter from your insurance agent, insurance carrier, or state fund (on their letterhead) verifying the EMR data listed above;
* Provide a copy of the last three years’ Experience Rating Calculation Sheets which your insurance carrier should forward to you annually; or
* Provide a copy of the pages of your last three years’ insurance policies that show the experience modification rate and the cover period.
 |
| **DEFINITIONS** |
| * **Medical Treatment Injury**—An injury resulting from a work accident or illness that does not result in lost time or restricted work where the contractor employee receives treatment administered by a physician or by registered personnel under the standard orders of a physician. Medical treatment, as defined, does not include first-aid cases, even though first-aid is administered by a physician or registered professional personnel.
* **Lost Time Injury**—Any injury or illness that results in the employee being unable to work the next scheduled shift, or any injury or illness where the employee, following medical treatment is:
	+ Assigned to a temporary job;
	+ Working at a permanent job less than full time; or
	+ Working at a permanently assigned job but unable to perform all the duties normally required.
* **Exposure Hours**—Number of actual hours worked by employees during the calendar year.
* **Lost Workdays**—Number of days injured or ill employees were scheduled to work but could not.
 |

|  |
| --- |
| Please provide the following information: |
| **Three previous calendar years:** | **20\_****\_\_\_** | **20\_\_\_\_** | **20\_\_\_\_** |
| Number of employees: |  |  |  |
| Number of medical treatment injuries: |  |  |  |
| Number of lost workday injuries: |  |  |  |
| Number of fatalities: |  |  |  |
| Exposure hours: |  |  |  |
| Number of lost workdays: |  |  |  |
| ***See DEFINITIONS above.*** |

**Type of work (Bureau of Labor Statistics Standard Industrial Classification Code)**

SICTitle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIC#\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **ARE INJURY AND ILLNESS REPORTS OR REPORT SUMMARIES SENT TO THE FOLLOWING?** | (Check One) | **HOW OFTEN?** |
|  | **YES** | **NO** |  |
| Field Superintendent | **[ ]**  | **[ ]**  |  |
| President of Firm | **[ ]**  | **[ ]**  |  |
| Safety Officer/Dept. in Company *(If yes, list name, title, and telephone number)* | **[ ]**  | **[ ]**  |  |
| Name:  |       | Title: |  | Phone: |       |
| Project Safety, Health, and Housekeeping Management and Inspections*(If yes, list name and title of persons who perform inspections)* | **[ ]**  | **[ ]**  |  |
| Names: |       | Titles: |       |
| Names: |       | Titles: |       |
| Names: |       | Titles: |       |
| List names and expected positions of key supervisory personnel planned for work at NTM facilities: |
| NAME | POSITION |
|       |       |
|       |       |
|       |       |
|       |       |

|  |  |  |
| --- | --- | --- |
| **TRAINING PROGRAM AVAILABLE FOR NEWLY HIRED OR PROMOTED SUPERVISORS?** | **[ ]  YES (See below)** | **[ ]  NO** |
| **IF YES, DOES IT INCLUDE THE FOLLOWING?** | (Check One) |
|  | **YES** | **NO** |
| Safe Work Practices | [ ]  | [ ]  |
| Inspection Techniques | [ ]  | [ ]  |
| Toolbox Safety Meetings | [ ]  | [ ]  |
| Emergency Procedures | [ ]  | [ ]  |
| First-aid Procedures | [ ]  | [ ]  |
| Accident Prevention | [ ]  | [ ]  |
| Fire Protection and Prevention | [ ]  | [ ]  |
| Pre-work Orientation | [ ]  | [ ]  |
| Post Construction Clean-up and Orientation | [ ]  | [ ]  |
| Hazard Communication | [ ]  | [ ]  |
| Health and Safety Regulatory Standards | [ ]  | [ ]  |
| **QUESTIONS** | (Check One) |
|  | **YES** | **NO** |
| Do you conduct inspections and tests of construction equipment, for example, slings, cranes, hand and power tools, electrical supply, and ground fault circuit interrupters? | [ ]  | [ ]  |
| Are records prepared and maintained as required by federal and state laws? | [ ]  | [ ]  |
| **IF OPERATORS OF EQUIPMENT ARE CERTIFIED, ENTER NAME OF PERSON/ORGANIZATION/CONSULTANT PROVIDING CERTIFICATION FOR:** |
| Cranes |       |
| Mobile Equipment |       |
| Fork Lift Trucks |       |

|  |
| --- |
| **INSURANCE: PLEASE PROVIDE NAME OF CARRIER, EXPIRATION DATE AND LIMITS FOR EACH OF THE FOLLOWING COVERAGES:** |
| Commercial General Liability Insurance: | Carrier: |       |
|  | Expiration Date: |       |
|  | Limits: |       |
| Vehicle Insurance: | Carrier: |       |
|  | Expiration Date: |       |
|  | Limits: |       |
| Workers’ Compensation Insurance | Carrier: |       |
|  | Expiration Date: |       |
|  | Limits: |       |
| Employee Liability Insurance: | Carrier: |       |
|  | Expiration Date: |       |
|  | Limits: |       |
| Excess Liability Insurance: | Carrier: |       |
|  | Expiration Date: |       |
|  | Limits: |       |

|  |
| --- |
| **NTM REQUIRES MINIMUM COVERAGES OF COMMERCIAL GENERAL LIABILITY INSURANCE AND EXCESS LIABILITY INSURANCE OWING TO THE RISK. PLEASE CONFIRM THE FOLLOWING:** |
| You have discussed minimum coverages with NTM’s contracting agent and are willing to provide at least the minimum coverages: | [ ]  Yes | [ ]  No |
| You and your insurance carrier are willing to list NTM as an additional insured on all policies except Workers’ Compensation Insurance: | [ ]  Yes | [ ]  No |
| You and your insurance carrier are willing to waive the right of subrogation with respect to NTM: | [ ]  Yes | [ ]  No |
| Do you have a current business relationship with a surety licensed to issue performance and payment bonds in Tennessee: | [ ]  Yes | [ ]  No |
| * If your answer is YES, please provide the name of the surety and approximate bonding limit per job:
 |
|  |
|  |
|  |
|  |
| **LICENSES: PLEASE PROVIDE THE FOLLOWING LICENSING INFORMATION:** |
| Are you currently authorized to do business in Tennessee? | [ ]  Yes | [ ]  No |
| Are you licensed as a contractor in Tennessee? | [ ]  Yes | [ ]  No |
| Tennessee Contractor License Classifications: |  |
| Tennessee Contractor License Limits: |  |
| Are you registered to purchase, receive or take possession of explosives in Tennessee? | [ ]  Yes | [ ]  No |
| Do you have employees trained and licensed as blasters? | [ ]  Yes | [ ]  No |
| **GENERAL** |
| Do you have a written Equal Opportunity Policy that you follow? | [ ]  Yes | [ ]  No |
| Do you have a written Americans with Disabilities Act (ADA) Policy that you follow? | [ ]  Yes | [ ]  No |
| **PLEASE PROVIDE A COPY OF EACH POLICY TO NTM.** |
| Do you have an agreement with any union representing some or all of your employees? If your answer is YES, please provide a description of the agreement on an attached sheet. | [ ]  Yes | [ ]  No |
| Have you been cited or sued for sexual or other employee harassment, an EEOC or Wage and Hour violation during the past five (5) years? If your answer is YES, please provide a description of each incident on an attached sheet. | [ ]  Yes | [ ]  No |
| Have you been involved in any lawsuit or administrative action not previously disclosed within the past five (5) years? If your answer is YES, please provide a description of each lawsuit or administrative action on an attached sheet. | [ ]  Yes | [ ]  No |

|  |
| --- |
| **COMMENTS BY CONTRACTOR OFFICIAL REFLECTING COMPANY SAFETY AND HEALTH POLICY:** |
|       |
|       |
|       |
|       |
| **QUESTIONNAIRE COMPLETED BY:** |
| NAME: |       | TITLE: |       |
| COMPANY:  |       | MSHA ID: |       |
| ADDRESS: |       |
|  |       |
| TELEPHONE:  |       | DATE: |       |

**INCLUDE IN AGREEMENT FILE**