SAFETY, HEALTH & ENVIRONMENTAL
SUBCONTRACTOR SAFETY CRITERIA QUESTIONNAIRE

Company Name:	Date:
Address:	
City:	State:
List Service(s) to be provided:	

1. Experience Modification Rates

   a) List your firm's Experience Modification Rate (EMR) for the three (3) most recent years. (*Information is available from your Workers' Compensation Insurance Carrier*)

Year	Interstate

   b) If your organization does not have an EMR or your EMR is greater than 1.10, please explain why.

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2. Please consolidate your firm's OSHA Form 300 injury and illness data for the last three (3) years and complete the following:

	Data	Year	Year	Year
a)	Number of Lost Workday Cases (not days lost)			
b)	Number of Restricted Workday Cases (not restricted days)			
c)	Number of Medical Treatment Cases* (not including first aid)			
d)	Total Recordable Cases (a + b + c)			
e)	Total Corporate Hours Worked (hourly and salaried employees)			
f)	Recordable Case Frequency Rate (RCFR) ([d x 200,000] / e)			

***Medical Treatment Case** is a case in which an on-the-job injury requires *other* than first aid treatment (and is not considered a restricted or lost workday) as defined by the U.S. Bureau of Labor Statistics recordability criteria (i e , prescribed medication, physical therapy - more than one visit, fractures, imbedded foreign body, etc) First aid injury treatment cases are *not* required to be added to the OSHA Form 300 log

   a) Does your organization have fewer than 10 employees? ☐ Yes ☐ No

   Note: If you check Yes. you are required to only complete rows d) and e) in the above table.

3. List any fatalities your firm has had in the last three (3) years. Include location, cause, and corrective actions. (*Attach supplemental information as required*)

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4 List any OSHA *REPEAT*, *WILLFUL*, or *CRIMINAL* citations your firm has had in the last three (3) years. Please describe. (*Attach supplemental information as required*)

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