



SUBCONTRACTOR PREQUALIFICATION QUESTIONNAIRE

CONTACT INFORMATION

NAME OF COMPANY: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHONE: _____ FAX: _____

CONTACT PERSON: _____

CONTRACTING SPECIALTY: _____

UNION: YES: _____ NO: _____

TYPE OF LICENSE: _____ LICENSE #: _____

YEAR IN BUSINESS: _____ OTHER: _____

LIST THE CORPORATE OFFICERS, PARTNERS OR PROPRIETORS:

NAME:	POSITION:
_____	_____
_____	_____
_____	_____
_____	_____

FINANCIAL AND INSURANCE INFORMATION

BANK: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHONE: _____ FAX: _____

CONTACT PERSON: _____

BONDING COMPANY: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHONE: _____ FAX: _____

CONTACT PERSON: _____

LIABILITY INSURANCE CO.: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHONE: _____ FAX: _____

CONTACT PERSON: _____

WORKERS COMPENSATION CO.: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHONE: _____ FAX: _____

CONTACT PERSON: _____

WILL YOU PROVIDE A "WAIVER OF SUBROGATION"? YES _____ NO _____

WHAT IS YOUR "EXPERIENCE MODIFICATION FACTOR"? _____

AUTO INSURANCE CO.: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHONE: _____ FAX: _____

CONTACT PERSON: _____

PROJECT EXPERIENCE

SIZE OF PROJECT: \$ _____ TO \$ _____

HAVE YOU EVER FAILED TO COMPLETE A PROJECT? YES _____ NO _____

IF YES, PLEASE EXPLAIN. _____

WHAT PERCENT OF YOUR WORK IS NORMALLY SUBCONTRACTED? _____ %

WHAT GEOGRAPHIC AREA DO YOU WORK IN? _____

WHAT PERCENT OF YOUR WORK IS : PUBLIC: _____ % PRIVATE: _____ %

HAVE YOU EVER BEEN INVOLVED IN AN ARBITRATION PROCEEDING OR LAWSUIT? YES _____ NO _____

IF YES, PLEASE EXPLAIN. _____

LIST 4 GENERAL CONTRACTORS THAT YOU HAVE WORKED FOR IN THE LAST 12 MONTHS:

COMPANY NAME	CONTACT PERSON	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST 4 MATERIAL SUPPLIERS THAT YOU HAVE PURCHASED FROM IN THE LAST 12 MONTHS:

COMPANY NAME	CONTACT PERSON	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DOES YOUR COMPANY HAVE AN "INJURY AND ILLNESS PREVENTION PROGRAM"? YES _____ NO _____

WHO IS THE PERSON RESPONSIBLE FOR THE SAFETY PROGRAM AT YOUR COMPANY? _____

DOES YOUR COMPANY CONDUCT ANY SPECIAL SAFETY TRAINING? YES _____ NO _____

IF YES, PLEASE EXPLAIN. _____

COMPLETED BY: _____

TITLE: _____

DATE: _____