

VENDOR PRE-QUALIFICATION STATEMENT

All subcontractors/vendors interested in working with LEMARTEC CORPORATION (Lemartec) are required to complete this form and return it to Lemartec.

The contents of this questionnaire will be considered confidential and used solely to determine your firm's qualifications. Please submit and direct all questions to: Procurement Department [prequalification@lemartec.com]

Based on the responses to questionnaire, additional information may be required.

Thank you.

I. Organization

Company Name

Company Address

City State Zip

Primary Contact Name

Telephone Fax Primary E-mail

Company Website

Federal Tax Payer ID#

Years in Business under this organization name Years

Type of Company: Corporation LLC Partnership Sole Proprietor

List all other names under which your organization or principles conducts business:

Is your company affiliated with any other company? Yes No
If so, please list here:

List Owners, Officers, and Key Personnel below.

Contact Name	Title	Contact Email	Contact Number	Years at Company

List Local and/or State Contractor licenses under which your company operates

License Type	Issuing Authority	License Number	Qualifier	Expiration Date

What categories of work (scopes) does your company perform?

A) _____	D) _____
B) _____	E) _____
C) _____	F) _____

Does your firm have any in-house fabrication capabilities? Yes No

If so, please describe below:

Please provide the number of personnel employed by your company per each description listed below:

Unskilled Craftsmen	<input type="text"/>	Skilled craftsmen	<input type="text"/>	Project Managers	<input type="text"/>
Architect / Engineers / Draftsmen	<input type="text"/>	Clerical	<input type="text"/>	Other	<input type="text"/>

Percentage of work self-performed by your own forces? %

Does your company hold any of the following certifications? (i.e.. MBE, WBE, CSBE, SBE, DBE, etc...)

Please attach certification letters to the back of this form.

Certification	Municipality

II. Bonding

Surety Company

Bonding Company

Bonding Company Address

City State Zip

Agent Name

Telephone

Single Limit Aggregate Limit

III. Insurance & Safety

Insurance Carrier Company

Agent Company

Agent Company Address

City State Zip

Agent Name

Telephone Fax

General Liability limits

Automobile Limits

Workers Compensation Policy Yes No

Umbrella Limits

List your Workers Compensation Experience Modification Rate for the past three years.

2015

2016

2017

Has your company received any OSHA violations/citations within the past (4) years? Yes No

If so, please explain below:

IV. Claims and Suits

Within the last five years, has there been any judgments, claims, arbitration proceedings or suits against your firm or its officers? If yes, please list on a separate sheet. Yes No

Has your firm filed any lawsuits or requested arbitration with regard to construction contracts within the last five years? If yes, please list on a separate sheet. Yes No

Has your company ever failed to complete any work it has been awarded? Yes No

Within the last five years, has any officer or principal of your organization ever been an officer or principal of another organization when it failed to complete a construction contract? Yes No

If so, please explain below (provide attachment for additional space if necessary):

List three trade references with which your firm does business:

Company Name	Address	Contact Name	Telephone

Please provide letters of references for projects completed from General Contractors and/or Clients.

V. Financial Information

Please attach current financial statement.

Annual revenue for the last four years

2014	\$	<input type="text"/>
2015	\$	<input type="text"/>
2016	\$	<input type="text"/>
2017	\$	<input type="text"/>

VI. Dunn & Bradstreet Information

Please attach most current D&B Comprehensive Report.

D-U-N-S Number:	<input type="text"/>
D&B Rating:	<input type="text"/>
Viability Score:	<input type="text"/>
Portfolio Comparison:	<input type="text"/>
Data Depth Indicator:	<input type="text"/>

I have answered all the questions above truthfully and to the best of my knowledge.

Signature

Title

Print Name

Date

Quality System		Check if N/A: <input type="checkbox"/>
Do you have a Quality Assurance System? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, number and qualification of Quality Assurance personnel, (include CQE, CQA, CRE, Certified Lead Assessor, etc.) _____		
Is your company ISO certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, at what facilities?		
	LOCATION	STANDARD (9001, 9002, 14001)
ATTACH copies of certificates for ISO certified facilities.		

Quality Control		Check if N/A: <input type="checkbox"/>	
Do you have a Quality Control department? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number and qualifications (AWS, CWI, ASNT Level 1, 2, 3, etc.) of shop inspectors per shift:			
Describe your procedure for Quality Control inspection of suppliers/subcontractors systems and practices during fabrication:			
Is all of your shop open to our inspectors: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, please explain:			
Who in your company is responsible for coordinating company or client-required inspection hold points?			
Do you have a controlled system for welding filler metal control and distribution: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have the ability to perform the following testing methods in-house?			
	YES	NO	If no, state name and location (city) of your supplier or third party agency:
Radiographic examination:	<input type="checkbox"/>	<input type="checkbox"/>	
Ultrasonic examination:	<input type="checkbox"/>	<input type="checkbox"/>	
Liquid penetrant/magnetic particle examination:	<input type="checkbox"/>	<input type="checkbox"/>	
Hardness testing:	<input type="checkbox"/>	<input type="checkbox"/>	

HEALTH SAFETY & ENVIRONMENT		Check if N/A: <input type="checkbox"/>
Do you have a Health, Safety & Environment Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Company SIC/NAICS code:
		SIC: _____ NAICS _____



Complete attached form (if requested)

SUPPLIER CERTIFICATION:

The undersigned certifies that the information provided herein is accurate and correct.

SIGNED: _____

NAME: _____

TITLE: _____

DATE: _____

HEALTH SAFETY & ENVIRONMENT (COMPLETE ONLY IF REQUESTED)

(Send these pages to the supplier only if information is required)

Section A

HSE CERTIFICATION : _____ EXPIRATION DATE : _____
 NAME (ex:VPP, STAR, etc.)

Section B

PERSON COMPLETING THE EVALUATION: _____
 PHONE NUMBER: () _____ FAX NUMBER: () _____
 ADDRESS: (If different from above)

Street Address _____ City _____ State _____ Zip _____
 TITLE: _____ SIGNATURE: _____

Do you have a HSE Manual for your facility? Yes No

If yes, please ATTACH for review. Also, attach Index of HSE procedures.

Section C

1. INJURY / ILLNESS STATISTICS

USE THE PREVIOUS THREE YEARS' INJURY & ILLNESS RECORDS TO COMPLETE THE FOLLOWING:

	20	Rate	20	Rate	20	Rate
NUMBER OF DAY AWAY FROM WORK CASES						
TOTAL NUMBER OF INJURIES / ILLNESSES REQUIRING MEDICAL ATTENTION BY A PHYSICIAN & DAW						
NUMBER OF FATALITIES						
NUMBER OF EMPLOYEE HOURS WORKED						
EMPLOYER MODIFICATION RATE						
NUMBER OSHA CITATIONS						
NUMBER EPA CITATIONS						

2. SERVICE CATEGORY (CHECK ONE):

- NONRESIDENTIAL BUILDING ELECTRICAL EQUIPMENT
 HEAVY (NON-HIGHWAY) CONSTRUCTION STEEL ERECTOR MECHANICAL
 PLUMBING, HEATING AND AIR CONDITIONING GENERAL CONTRACTOR OTHER (Specify) _____

3. SUPERVISOR HSE MEETINGS

DO YOU HOLD ON-SITE HSE MEETINGS WITH FIELD SUPERVISORS? YES, If so how often? NO
 WEEKLY MONTHLY

4. HSE INSPECTIONS

DO YOU CONDUCT PROJECT HSE INSPECTIONS? YES NO
 WHO CONDUCTS THIS INSPECTION? _____ HOW OFTEN?
 WEEKLY MONTHLY LESS OFTEN, AS NEEDED

5. ACCIDENT/INCIDENT RECORDS

HOW ARE ACCIDENT/INCIDENT STATISTICS REPORTED?

	REPORTED		HOW OFTEN ARE THEY REPORTED?		
	YES	NO	MONTHLY	QUARTERLY	ANNUALLY
ACCIDENTS/INCIDENTS TOTALED FOR ALL COMPANY					
ACCIDENTS/INCIDENTS TOTALED BY PROJECT					
SUBTOTALED BY SUPERINTENDENT					
SUBTOTALED BY SUPERVISOR					

6. ACCIDENT/INCIDENT REPORTING

WHO RECEIVES ACCIDENT/INCIDENT STATISTICAL REPORTS WITHIN YOUR COMPANY? _____

HOW OFTEN ARE THEY REPORTED? _____

	YES	NO	MONTHLY	QUARTERLY	ANNUALLY
FIELD SUPERINTENDENT					
VICE PRESIDENT					
PRESIDENT / CEO					

7. WRITTEN HSE PROGRAM

DO YOU HAVE A WRITTEN HSE PROGRAM? YES NO (please provide a copy of the program)

8. HSE PROGRAM ELEMENTS

DOES YOUR HSE PROGRAM INCLUDE THE FOLLOWING ELEMENTS?

	YES	NO	N/A		YES	NO	N/A
CORPORATE HSE POLICY, SAFETY RULES OR PROCEDURES				AUDIT, ASSESSMENT AND / OR INSPECTION			
CONCRETE & MASONRY				STAIRWAYS AND LADDERS			
EXCAVATION				PERSONAL PROTECTIVE EQUIPMENT			
HEARING PROTECTION				SCAFFOLDING			
RESPIRATORY PROTECTION				HAND & PORTABLE POWERED TOOLS & OTHER HAND-HELD EQUIPMENT			
WALKING / WORKING SURFACES				POWERED PLATFORMS, MANLIFTS & VEHICLE MOUNTED WORKING PLATFORMS			
WORKING AT HEIGHTS / FALL PREVENTION				WELDING & CUTTING			
SIGNS, SIGNALS & BARRICADES				HAZARDOUS MATERIALS			
HOUSEKEEPING				MEDICAL EVALUATION & EXAMS			
FIRE PREVENTION & PROTECTION				CONFINED SPACE			
FIRST AID PROCEDURES				COMPRESSED GAS & COMPRESSED AIR EQUIPMENT			
EMERGENCY PROCEDURES				HSE (HAZCOM) COMMUNICATION			
ROLLOVER PROTECTIVE STRUCTURES; OVERHEAD PROTECTION				OCCUPATIONAL HEALTH & ENVIRONMENTAL CONTROL			
MEDICAL AND FIRST AID				SUBSTANCE ABUSE			
BLASTING & USE OF EXPLOSIVES				GENERAL ENVIRONMENTAL CONTROLS			
EMPLOYEE TRAINING PROGRAM				ACCIDENT/INCIDENT INVESTIGATION			
MATERIAL HANDLING AND STORAGE				REGULATED CHEMICALS			
MOTOR VEHICLES, MECHANIZED EQUIPMENT & MARINE OPERATIONS				COMMERCIAL DIVING OPERATIONS			
CRANES, DERRICK, HOISTS, ELEVATORS AND CONVEYORS				ENVIRONMENTAL REGULATIONS PROGRAMS (SEE PROCEDURE)			
ELECTRICAL							

9. NEW EMPLOYEE HSE ORIENTATION

DO YOU HAVE A HSE INDUCTION PROGRAM FOR NEW HIRES? NO YES

IF YES, DOES IT INCLUDE ANY OF THE FOLLOWING?

	YES	NO	N/A		YES	NO	N/A
HEAD and FOOT PROTECTION				HAZARD COMMUNICATIONS			
EYE PROTECTION				TRENCHING & EXCAVATION			
HEARING PROTECTION				SIGNS & BARRICADES			
RESPIRATORY PROTECTION				ELECTRICAL			
FALL PREVENTION				CRANE & RIGGING			
HOUSEKEEPING				VEHICLES			
FIRE PREVENTION & PROTECTION				LADDERS AND SCAFFOLDING			
FIRST AID EMERGENCY TREATMENT				HAND TOOLS / POWER TOOLS			
EMERGENCY EVACUATION PROCEDURES				OCCUPATIONAL HEALTH			
ACCIDENT / INCIDENT REPORTING				ENVIRONMENTAL ASPECTS			

				SUBSTANCE ABUSE			
10. SUPERVISOR HSE TRAINING:							
DO YOU HAVE A PROGRAM TO DEVELOP NEWLY HIRED OR PROMOTED SUPERVISORS? <input type="checkbox"/> NO <input type="checkbox"/> YES							
IF YES, DOES IT INCLUDE ANY OF THE FOLLOWING?							
	YES	NO	N/A		YES	NO	N/A
SAFE WORK PRACTICES				ACCIDENT /INCIDENT REPORTING & INVESTIGATION			
SUPERVISOR HSE RESPONSIBILITIES				EMPLOYEE DISCIPLINE			
HSE MEETING				HSE COMMUNICATION			
EMERGENCY PROCEDURES				SUBSTANCE ABUSE AWARENESS / PREVENTION			
FIRST AID PROCEDURES				ENVIRONMENTAL ASPECTS			
11. EMPLOYEE HSE MEETINGS							
DO YOU CONDUCT HSE MEETINGS? <input type="checkbox"/> NO <input type="checkbox"/> YES, If so how often?							
<input type="checkbox"/> WEEKLY	<input type="checkbox"/> BI-WEEKLY	<input type="checkbox"/> MONTHLY					
12. COMPANY HSE PROGRAM MANAGER:							
IDENTIFY THE PERSON WITHIN YOUR COMPANY DIRECTLY RESPONSIBLE FOR HSE PROGRAM MANAGEMENT:							
_____				_____			
NAME				TITLE			
COMPLETED BY:	_____			PHONE:			_____
TITLE:	_____			DATE:			_____



a MasTec company

MWBE Supplier/ Subcontractor Information Request

In our growing efforts to support the development and utilization of companies owned by minorities and woman, we are asking you to complete the following information so we can accurately track our progress. With the rapid changes in today's business environment, we strive to create and maintain strong alliances with our suppliers and subcontractors.

For more information on the below groups, visit <http://www.mwbe-enterprises.com>

Minority Business Enterprise (check below) *MBE Certified [Y/ N]: (Circle)

- Subcontinent Asian Indian
- Asian Pacific Americans
- Black Americans
- Hispanic Americans
- Native American

Disadvantage Business Enterprise (Check below) *DBE Certified [Y/ N]: (Circle)

- Disabled
- Veteran-Owned

Small Disadvantaged Business Entities (Check below) *SDB Certified [Y/ N]: (Circle)

- Small Business
- Hub Zone - For more information, please visit <http://www.sba.gov/hubzone>

Women Business Enterprise (Check below) *WBE Certified [Y/ N]: (Circle)

- Women Owned

***If certified, please provide a copy of your certification along with this form.**

Business Owner's Name: _____

Signed: _____ Date: _____

Your help is greatly appreciated.