



SUBCONTRACTOR QUALIFICATION APPLICATION

(Completion of this Qualification Form is Required of ALL Subcontractors)

GENERAL COMPANY INFORMATION:

Legal Company Name:			
Street Address:		Mailing Address:	
City, State, Zip:		City, State, Zip:	
Main Office Phone:		Main Office Fax:	
Contractor Registration No:		State Tax No. (UBI):	
D/B/A:		Parent Company:	
Company Organization: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC			
Officers / Partners / Principals:		Signature Authority:	
NAME:	TITLE:	Contracts	Change Orders
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Origination:		Other/Former Names:	
M/W/D/B/E Certifications:		Certifying Agency (s):	
Key Contact:		Email:	
Phone:		Fax:	
Emergency Contact:		Email:	

TRADE INFORMATION:

Scope Bid:	CSI/DIV	<input type="checkbox"/> Self-Performed	<input type="checkbox"/> Subcontracted
Scope Bid:	CSI/DIV	<input type="checkbox"/> Self-Performed	<input type="checkbox"/> Subcontracted
Scope Bid:	CSI/DIV	<input type="checkbox"/> Self-Performed	<input type="checkbox"/> Subcontracted
Scope Bid:	CSI/DIV	<input type="checkbox"/> Self-Performed	<input type="checkbox"/> Subcontracted
Scope Bid:	CSI/DIV	<input type="checkbox"/> Self-Performed	<input type="checkbox"/> Subcontracted
Union Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Union:	Local No.	Agreement Expires:	
Union:	Local No.	Agreement Expires:	
Union:	Local No.	Agreement Expires:	





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Please provide the contact information for your Insurance Agent / Broker

Name:	Title:
Phone:	Fax:
Email:	

IMPORTANT

Please attach a SAMPLE Certificate of Insurance to evidence coverage stated together with a SAMPLE of the Additional Insured Endorsement stipulating primary coverage used by your carrier.

SAFETY INFORMATION:

Workers' Compensation Experience Modification Rate (EMR) for the three most recent years:

Jan 1, 20__ Rate:	Jan 1, 20__ Rate:	Jan 1, 20__ Rate:
In the last three (3) calendar years:	20__	20__
How many man-hours did your employees work?		
How many recordable accidents did your firm have?		
How many restricted (light duty) workday <u>cases</u> did your firm have?		
How many lost day <u>cases</u> did your firm have?		
- Total number days away from work for lost day <u>cases</u>		
What was your firm's incident rate for recordable <u>accidents</u> ? (OSHA recordable accidents x 200,000 / man-hours worked)		
What was your firm's incident rate for time loss <u>claims</u> ? (Lost workday incidents x 200,000 / man-hours worked)		
Average No. of Employees:	Have you been cited by OSHA / WISHA in the last 5 years:	
Does your company have a written Safety Program? (Must be available for review upon request)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your company have a return to work / light duty program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your company have a written substance abuse / testing policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your company review the safety management systems of your tier subcontractors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Safety Program Managers Name or Contact Person:		
Title:	Cell Phone:	Office Phone:





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FINANCIAL INFORMATION:

State your firm's projected total revenue for current year and actual total revenue for each of the previous three years.

20____ \$	20____ \$	20____ \$
Has your company or any of its owners, officers or major shareholders ever petitioned for bankruptcy, been terminated on a contract or failed to complete work awarded it?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, explain:		
Is your company or any of its owners, officers or major shareholders currently involved in any arbitration or litigation or have any outstanding judgments or claims against it?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, explain:		

OWNER / GENERAL CONTRACTOR REFERENCES

List Owner and/or General Contractor references, including contact name whom we may call.

Owner / General Contractor	Contact Name	Phone	Email

TRADE REFERENCES

Major Supplier / Tier Sub	Contact Name	Phone	Email

WORK IN PROGRESS SCHEDULE





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List current, ongoing projects with approximate contract amount & anticipated completion date or attach a separate list.

Project	Contract Amount	Projected Completion	General Contractor

COMPLETED WORK SCHEDULE

List projects commenced in the last 3 year or attach a separate list.

Project	Contract Amount	Projected Completion	General Contractor

PLEASE ATTACH YOUR LAST 2 YEARS' AUDITED, COMPILED OR REVIEWED FINANCIAL STATEMENTS TO THE END OF THIS FORM.

IMPORTANT

While review of Subcontractor financial information is an important and necessary part of the qualification process, Arundel Group Holding LLC. does recognize the proprietary and confidential nature of these documents. Please be assured this information will be handled with the utmost respect to your firm's privacy. Please feel free to contact the Estimating Department at info@arundelgroupllc.com if you'd like to discuss protection and handling of this sensitive information.

The following signature is from an authorized representative of the company & attest to the accuracy of the information provided above.

Name/Title

Date:

