Safety Performance Questionnaire

Company Name:_Click here to enter text.

Address: Click here to enter text.

Individual Completing this Questionnaire: Click here to enter text.

Position within the company: Click here to enter text.

Phone Number & Email: Click here to enter text.

Safety Program

1. Do you have a written safety program is it updated regularly? ☐Yes ☐No
2. When was it last updated? Click here to enter text.
3. Does your company have a written Drug & Alcohol Program? ☐Yes ☐No
4. Do you employ full a time safety representative(s)? ☐Yes ☐No
5. If yes, provide the Name, Phone Number, of the individual. Click here to enter text.
6. Are your employees properly trained for their tasks? ☐Yes ☐No
7. Will you have a competent person on the project when required by the task? ☐Yes ☐No
8. Are weekly safety meetings conducted? ☐Yes ☐No
9. Does your company have a procedure for identifying hazards and implementing corrective actions? Such as JHA's, AHA's, JTA's. ☐Yes ☐No
10. Are jobsite safety inspections conducted? ☐Yes ☐No
11. If yes, how often? ☐Daily ☐Weekly ☐Bi-Weekly ☐Monthly ☐Quarterly ☐Other
12. Who performs the inspections?

Safety Statistics

1. In the last 5 years, has your company been cited by Federal and/or State OSHA? ☐Yes ☐No
2. If yes, please provide a description(s) of the citation(s), final outcomes, and corrective actions that were implemented? Use an additional sheet if necessary.
   Click here to enter text.

List the last 5 previous years.

Year	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Hours Worked					
Recordable Incident Rate					
Days Away, Restricted, Transferred, Case Rate					
Lost Time Incident Rate					
EMR					

If the EMR is greater that 1.0 please provide an explanation.