Central Michigan University
University Engineering and Planning

Pre Qualification Form (PQF)
For Contractors

Please submit all Pre-Qualification Forms to:

Central Michigan University
University Engineering & Planning
Combined Services Building 206
Mt. Pleasant, MI 48859
Phil Tanner: tanne1p@cmich.edu

General Information

*Required fields must be filled out completely to be submitted for approval.

*Company Name:	*Telephone:	*Fax:
*Street Address:	*Mailing Address:	
*Date:	E-Mail Address:	

1. *Officers

   President:

   Vice President:

   Treasurer:

2. *How many years has your organization been in business under your present firm name?

3. *Parent Company Name:

City:	State:	Zip:

4. *Under Current Management Since (Date):

5. *Contact for Insurance Information:

Title:	Telephone:	Email:

6. *Insurance Carrier(s)

Name	Type of Coverage	Telephone

7. *Are you self-insured for Worker's Compensation Insurance? Yes □ No □		
8. *Contacts for Requesting Bids (list 2):		
Name/Title:	Telephone:	Email:
9. *Pre-Qualification Form completed By:		
Title:	Telephone:	Email:

Organization

1. Form of Business: Sole Owner: □ Partnership: □ Corporation: □		
2. Describe Services Performed: □ Construction □ Construction Design □ Original Equip. Manufacturer & Installer □ Project Maintenance □ Maintenance □ Service Work (e.g. janitorial, clerical) □ Other		
3. Describe Additional Services Performed:		
4. List other types of work within the services you normally perform that you subcontract to others:		
8. Annual Dollar Volume for the Past Three Years:		
20_____ $	20_____ $	20_____ $
9. Largest Job During the Last 3 Years: $		
10. Your Firm's Desired Project Size:		
Maximum:	Minimum:	
11. D & B Financial Rating: Current audited financial statement is requested. If not submitted with this package, CMU will require submission of this document before award of contracts $2,000,000 and greater.		
Annual Sales $	Net Worth $	
12. Bank Line of Credit (amt):	Bank Reference(s):	

13. Bonding Capacity: $	

Work History

1. Largest dollar valued jobs in progress:				
Customer/Location	Type of Work	Size - $M	Contact	Telephone

2. Largest dollar valued jobs in the past three years:				
Customer/Location	Type of Work	Size - $M	Contact	Telephone

3. Are there any judgements, claims or suits pending or outstanding against your company?

□ Yes □ No

If yes, please attach details

4. Are you or have you ever been involved in any bankruptcy or reorganization proceedings?

□ Yes □ No

If yes, please attach details

5. Has your organization ever failed to complete any work awarded to it?

6. Has your organization been involved in any lawsuits or arbitration with regard to construction contracts within the last five years?

7. 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? (If the answer is yes, please attach details)

Safety and Health Performance

1. Workers Compensation Experience Modification Rate (EMR) Data:

a) EMR is:
- □ Interstate Rate
- □ Intrastate Rate
- □ Monopolistic State Rate
- □ Dual Rate

b) EMR for last three years:
_____ 20_____
_____ 20 _____
_____ 20 _____

c) State or Origin:

d) EMR Anniversary Date:

2. Injury and Illness Data:

a) Employee hours worked last three years (excluding subcontractors)

Year: 20_____	Hours:
Year: 20 ____	Hours:
Year: 20 ____	Hours:

b) Provide the following data (excluding subcontractor) using your OSHA 200 Forms for the past three (3) years: *(Notes: Data should be the best available data applicable to the work in this region or area. If your company is not required to maintain OSHA 200 forms, please provide information from your Worker's Compensation Insurance carrier itemizing all claims for the last three years).*

Injury related fatality:
20__ Number: Rate:

20__ Number: Rate:

20__ Number: Rate:

Lost workday cases injuries involving days away from work, or days of restricted work activity or both:

20__ Number: Rate:

20__ Number: Rate:

20__ Number: Rate:

Lost workday case injuries involving days away from work:

20__ Number: Rate:

20__ Number: Rate:

20__ Number: Rate:

Injuries involving medical treatment only:

20__ Number: Rate:

20__ Number: Rate:

20__ Number: Rate:

Total OSHA Recordable Injury Rate: 20__ Number: Rate: 20__ Number: Rate: 20__ Number: Rate:
3. Have you received any regulatory (EPA, OSHA, etc.) citations in the last three years? Yes □ No □

Safety and Health Programs and Procedures

1. Highest ranking safety/health professional in the company:		
Title:	Telephone:	Fax:
2. Do you have or provide the following:		
a) Full time Safety/Health Director. Yes □ No □		
b) Full time Safety/Health Supervisor: Yes □ No □		
c) Full time Job Safety/Health Coordinator: Yes □ No □		
3. Do you have or provide the following:		
a) Safety/Health incentive program: Yes □ No □		
b) Company paid safety/health training: Yes □ No □		
4. Do you have a written Safety & Health Program? Yes □ No □ If yes, please submit		
5. Do you have a substance abuse program including Testing? Yes □ No □		
6. Do your employees read, write and understand English such that they can perform their job tasks safely without an interpreter? Yes □ No □ If no, provide a description of your plan to assure that they can safely perform their jobs.		

* _____
Print Firm Name/Principal

* _____
Signature/Principal

* _____
Date

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Contractor Evaluation

DO NOT FILL OUT - OWNER USE ONLY

The Contractor is:

☐ Acceptable for Approved Contractor List

☐ Conditionally Acceptable for Approved Contractor List

Conditions:

Date Contractor Notified _____

Approved By: _____ Date: _____

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Reviewer: _____ Date: _____

Reviewer: _____ Date: _____