

# USA CONTRACTOR PRE-QUALIFICATION



Thank you for your interest in supporting Black Diamond. In order to best match your capabilities with upcoming opportunities, please fill out the following information and return to [prequalification@blackdiamondgroup.com](mailto:prequalification@blackdiamondgroup.com)

**Please select which Black Diamond entity you will be working for:**

BOXX Modular Inc.                      Black Diamond Energy Services, Inc.                      MPA Systems LLC

All questions must be answered thoroughly. Incomplete responses will result in your company's HSE qualification submittal potentially being denied. Depending on the evaluation, the subcontractor may be asked to submit risk mitigation or HS&E execution plans.

To comply with our HSE requirement, we expect all subcontractors, and vendors accessing a location or project site, to provide the following information (check attached):

OSHA 300 A Summary Logs - required for companies with 10 or more employees.

EMR verification from your insurance carrier.

Health, Safety and Environment Manual including policies and procedures in PDF format (if applicable)

\*Only required for sub-contractors performing work on a project site.

Completed Prequalification Package including Part 2 (If applicable)

Void Cheque or EFT Details and W9

**All information and the completed qualification form must be submitted as a single submittal.**

Part 1 – General Information				
Legal Company Name				
Federal Tax Number		Current Licenses:		
Company Type				
Corporation	Partnership	Individual	Joint Venture	Limited Liability Company
Street Address				
City		State	Zip Code	
Email Address				
Form Completed By		Company Contact		

## Part 1 – General Information continued

Telephone Number Mobile / Alternate Phone Number

Fax Number Federal Tax ID Number

Date (YYYY/MM/DD) Type of Work Code(s)\*

## Part 2 – Safety Information

Provide your EMR for the current year and two previous:

Current: Last: Previous to last:

Are your employees 10 hr. OSHA Certified? Yes No

If yes how many positions?

Are your employees 30 hr. OSHA Certified? Yes No

If yes how many positions?

In the table below, provide the three most recent full years of incident information for your company:

Year	Average # of Employees	Exposure Or Employee Hours	Number of Recordable Cases	DART Rate	ORIR	# of Lost Workdays	Severity Rate	# of Fatalities	Vehicle Accident Rate
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)

\*The reference guide for filling out the table can be found on page 6.

Has your company received any health, safety, and environmental citations from a regulatory agency during the last three (3) years? Yes No

If yes, please provide details, including copies of the citations.

## Part 2 – Safety Information continued

Does your company have a written Alcohol and Substance Abuse Program?  
 If yes, please attach a copy to this document. Yes      No

If no, is your company willing to work under Black Diamond's  
 Alcohol and Substance Abuse Program? Yes      No

Does your company have a written Occupational Health and Safety program?  
 If yes, please attach a copy to this document. Yes      No

Please indicated if your company has any of the following:

An Affirmative Action Plan for employees	Yes	No
Training/orientation on sexual harassment in the workplace	Yes	No
A written Disciplinary Policy	Yes	No
A written Hazardous Communication Program	Yes	No
Safety orientation for new hires	Yes	No
Mandatory weekly safety meetings	Yes	No
A designated Safety Officer for your company	Yes	No
A Substance Abuse Policy	Yes	No
Pre-hire Testing	Yes	No
Post-hire/Random Testing	Yes	No

**If you do not have a written OH&S program or an HSE manual, please sign the following indicating that you agree to adhere to Black Diamond's HSE program. Black Diamond's HSE manual will be provided to you.**

Identify the individual within your company directly responsible for the HSE program administration.

Name: \_\_\_\_\_ Position \_\_\_\_\_

## Part 3 – References

**Company Reference 1** Contact Name and Phone Number

Project Description

**Company Reference 2** Contact Name and Phone Number

Project Description

## Part 3 – References continued

Company Reference 3	Contact Name and Phone Number
Project Description	

## Part 4 – Contractual and Associations

If relevant to your company, include an explanation of all occurrences from the list below that have taken place in the last 5 years, or indicate “no” if irrelevant. Provide sufficient and appropriate detail information such as “project name, owner, contact person and contact phone number, and amount of contract, etc.”

Any judgments, claims or suits pending or outstanding against your company? If yes, include a brief explanation of each.	Yes	No
Any judgments, claims or suits pending or outstanding by you against a client or general contractor? If yes, include a brief explanation of each.	Yes	No
Any citations by OSHA for violations in the last five (5) years? If yes, please include list of violations and status	Yes	No
Any State or Federal Prevailing Wage violations or judgments? If yes, please include list of violations and status.	Yes	No
Have you worked for Black Diamond under your current or another company name? If yes, under which company name?	Yes	No

## Part 4 – Contractual and Associations continued

Have you previously worked on a Black Diamond project.  
 If yes, list up to three (3) most recent projects.

Yes       No

## Part 5 – Insurance Requirements

Minimum requirement for liability insurance of \$2,000,000 and \$1,000,000 for Workers Compensation. Failure to provide proof may result in your company or firm being disqualified to work on any project or location.

Insurance Type	Insurance Company	Limits	Date of Renewal
Automobile			
Employers Liability			
General Liability			
Excess Insurance			
Bonding Company		Bonding Capacity	

Workers Compensation Insurance. (Must be current). Certificate of insurance naming:  
**BOXX Modular Holdings Inc. 3475 High River Road Fort Worth, TX 76155** as additional insured and show  
**Commercial General Liability with a minimum of \$1,000,000 coverage.**

## Part 6 – Financial Summary

D&B (Dun & Bradstreet) #:

## Part 7 – Signature

I certify that the information in this application is correct and complete. This document must be signed by a company officer or authorized representative.

Name of Company Principal

Signature of Company Principal

Date (YYYY/MM/DD)

## Part 8 – Form Information

### Guidance for Completing HSE Table (page 2)

**(A) YEAR:** List the three most recent full calendar years. If less than a year, please specify months.

**(B) Average # of Employees:** List the average # of employees who worked during the year. An employee shall be defined as any person engaged in activities for an employer from whom direct payment for services is received. Include working owners and officers.

**(C) Exposure or Employee Hours:** List the total number of hours worked during the year by all employees, including those in operating, production, maintenance, transportation, clerical, administrative, sales and all other activities.

**(D) Number of Recordable Cases:** List the total number of Recordable cases that occurred in that year. Recordable cases are any work-related injury case requiring more than first aid and all occupational illnesses. Recordable cases include all occupational illnesses, and all occupational injuries resulting in days away from work, restricted work activity, temporary or permanent transfer, medical treatment other than first aid, loss of consciousness, significant injury or illness diagnosed by a physician or other health care professional, or the termination of an injured or ill employee.

**(E) DART Rate (Days Away, Restricted or Transferred):** A mathematical calculation that describes the number of recordable injuries and illnesses per 100 full-time employees that resulted in days away from work, restricted work activity and/or job transfer that a company has experienced in any given time frame.

**(F) ORIR:** OSHA Recordable Incident Rate required for companies with 11 or more employees.

**(G) Number of Days Away from work:** List the total number of days away from work experienced by all employees during the year. For the purposes of this questionnaire, days away from work with restricted activity should not be added in this column. Only Recordable cases that result in one or more days away from work should be counted. Remember to count the number of calendar days the employee was unable to work as a result of the injury or illness regardless of whether or not the employee was scheduled to work on those days (vacations holidays and weekends are included)!

**(H) Severity Rate:** 
$$\frac{\text{Total number of lost Workdays} \times 200,000}{\text{Exposure or Employee Hours}}$$

**(I) EM R- Experience Modification Rate:** We require verification for the EMR, and discount rate data requested in the questionnaire, any of the following methods would be acceptable.

- A letter from your insurance agent, insurance carrier, or state fund (on their letterhead), verifying the EMR or discount rate listed above
- A copy of the last three (3) years' experience rating calculations sheets, which your insurance carrier should forward to you annually.
- A copy of the page of your last three years insurance policies that show the modification rate and the coverage period.

## Part 8 – Form Information continued

**(J) Number of Fatalities:** List the total number of fatalities that result from occupational injuries or illnesses. Deaths that occur in the workplace but are not the result of occupational injuries should not be included.

**(K) Vehicle Accident Rate:** 
$$\frac{\text{Total Vehicle Accidents} \times 1\,000\,000}{\text{Total Miles Driven}}$$

Additional Information: Additional information concerning injury and illness record keeping can be found in 29 CFR 1904 and OSHA'S "Recordkeeping Guidelines for Occupational Injuries and Illness" booklet.

**First Aid Case:** Any one-time treatment and subsequent observation of minor scratches, cuts burn, splinters, and so forth which do not require medical care even though provided by physician or registered professional personnel. These are not included in the TRIF calculation.

**Medical Treatment Case:** Any treatment (other than for first aid) administered by a physician or by registered professional personnel under the standing orders of a physician. These are not to be confused with First Aid Cases.

**Lost Workday Case/ Lost Workday:** An injury involving time away from work. Time begins on the day following the injury and includes all regularly scheduled workdays. Weekends or days when no actual work time is lost because the employee could not have worked even if not injured are not included.

**Restricted Workday Case:** Any work-related or incurred injury/illness which involves days of restricted work activity.

**Recordable Injury:** Work related or incurred injury/illness, which required medical attention by a physician; as opposed to treatment by a physician, which is of a first aid only or one-time (non-serious) nature. Medical Treatment - Any treatment (other than for first aid) administered by a physician or by registered professional personnel under the standing orders of a physician.

**Work-Related Case:** An injury or illness suffered by an employee, which results from a work accident or from an exposure involving a single incident in the work environment or an illness caused by exposure to environmental factors associated with employment. Occupational Injury - Any injury such as a cut, fracture, amputation, etc., which results from a work accident or from an exposure involving a single incident in the work environment. Occupational Illness - Any abnormal condition or disorder of an employee, which results from an exposure to environmental factors associated with employment.