

Standardized Pre-Qualification Form (PQF)

GENERAL INFORMATION		
1. Company Name: Scott Electric Company	Telephone: 361-884-6326	Fax: 361-884-9612
Street Address: 2001 N. Port Avenue	Mailing Address: P.O. Box 1819	
Corpus Christi, Texas 78401	Corpus Christi, Texas 78403	
	Web Site: http://www.scott-electric.com	
Contact Person: Lonnie Robisheaux	Email: Lonnie@scott-electric.com	
2. Officers		
President: Sarah Moore	Years With Company 19 years	
Secretary: Diana Hope	38 years	
Vice President: Mike Hope	38 years	
3. How many years has your organization been in business under your present firm name? 95		
4. Parent Company Name: Same		
City: Corpus Christi	State: Texas	Zip: 78401
Subsidiaries: Scott Air Conditioning & Heating, Scott Telecom, Coastal Kitchens		
5. Under Current Management Since (Date): 1/1/1975		
6. Contact for Insurance Information: Sarah Moore		
Title: President	Telephone: 361-884-6326	Fax: 361-884-9612
7. Insurance Carrier(s):		
Name	Type of Coverage	Telephone
Swantner & Gordon	All	361-883-1711
9. Contact for Requesting Bids: Mike Hope		
Title: Vice President	Telephone: 361-884-6326	Fax: 361-884-9612
10. PQF Completed By: Lonnie Robisheaux		
Title: Safety Director	Telephone: 361-884-6326	Fax: 361-884-9612

ORGANIZATION

11. Form of Business: Sole Owner Partnership Corporation

12. Percent Minority/Female Owned: 77% | EEO Category: WBE

13. A. Describe Services Performed: SIC Code: 1731

- | | |
|---|---|
| <input checked="" type="checkbox"/> Construction
<input checked="" type="checkbox"/> Construction Design
<input type="checkbox"/> Original Equipment Manufacturer and Installer
<input checked="" type="checkbox"/> Project Maintenance
<input checked="" type="checkbox"/> Maintenance | <input type="checkbox"/> Original Equipment Manufacturer and Maintenance
<input checked="" type="checkbox"/> Service work (e.g., janitorial, clerical, etc.)
<input type="checkbox"/> Manpower and Resource
<input checked="" type="checkbox"/> Turnaround |
|---|---|

B. Work Categories

Check the categories in which you are interested in bidding and in which you are qualified to perform work. Feel free to attach additional information clarifying your capabilities and specialties.

(C) denotes work done by company employees

(S) denotes work done by subcontractors

C S 1. Air Conditioning/Refrigeration

C S 11. Field Maintenance

Comfort Cooling/HVAC

General

Process Refrigeration

Hot Tap/line stops

2. Buildings

Leak Sealing (online)

Remodeling

Field Machining

New (steel, brick, block, other)

Tank/Vessel Code

3. Cleaning

Boiler Code

Industrial

Exchanger Retubing

Janitorial

Rotating Equipment

4. Civil

Valve

Concrete

Cooling Tower

Excavation/Grading

High Alloy Welding (list type)

Paving

Lead Lining

- Asphalt

Glass Lining

- Concrete

Heat Treating

Nonmetallic materials

Pipe Fabrication

Mobil Equipment Repair

5. Demolition/Dismantling

12. New Construction

6. Electrical

13. Painting

General

14. Refractory/Acid Brick

High-voltage/High-line

15. Rigging/Equipment Erection

Heat Tracing

16. Scaffolding

Cathodic Protection

17. Scale Maintenance

Grounding Systems

7. Inspection & Testing

18. Structural Steel Fab/Erection

General NDT

Infrared Scanning

19. Tanks - Field Erection

Eddy Current Testing

Acoustic Emission

Column Scanning

Civil/Soils

High Voltage Electrical

20. Other

Electrical Ground Inspection

Fiberglass Inspection

Other

SAFETY & HEALTH PERFORMANCE

25. Workers Compensation Experience Modification Rate (EMR) Data

- a. EMR is:
- Interstate rate
- Intrastate rate
- Monopolistic State rate
- Dual rate
- b. EMR for three last years:
- | | |
|-----|------|
| .46 | 2012 |
| .45 | 2013 |
| .53 | 2014 |
- c. State of Origin: Texas
- d. EMR Anniversary Date: 4/1/2015

26. Injury and Illness Data:

a. Employee hours worked last three years excluding subcontractors)

Hours / Year	2012	2013	2014
Field	835,643	869,870	823,722
Total	856,853	893,371	865,355

b. Provide the following data (excluding subcontractor) using your OSHA 200 Forms from the past three (3) years:

Notes: (1) Data should be the best available data applicable to the work in this region or area.

(2) 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 3 years)

	2012		2013		2014	
	No.	Rate	No.	Rate	No.	Rate
Injury related fatality <u>Total Col. 1 x 200,000</u> Rate = <u>Total Employee Hours</u>	0	0.00	0	0.00	0	0.00
Lost workday case injuries involving days away from work, or days of restricted work activity, or both. <u>Total Col. 2 x 200,000</u> Rate = <u>Total Employee Hours</u>	1	0.23	4	0.90	3	0.69
Lost workday case injuries involving days away from work. <u>Total Col. 3 x 200,000</u> Rate = <u>Total Employee Hours</u>	0	0.00	2	0.45	0	0.00
Injuries involving medical treatment only. <u>Total Col. 6 x 200,000</u> Rate = <u>Total Employee Hours</u>	8	1.87	15	3.36	7	1.62
Total OSHA Recordable Injury Rate <u>(Total Col. 1 + 2+ 6) x 200,000</u> Rate = <u>Total Employee Hours</u>	4	0.87	4	0.90	3	0.69
Illness related fatality <u>Total Col. 8 x 200,000</u> Rate = <u>Total Employee Hours</u>	0	0.00	0	0.00	0	0.00
Lost workday case illnesses involving days away from work, or days of restricted work activity, or both. <u>Total Col. 9 x 200,000</u> Rate = <u>Total Employee Hours</u>	0	0.00	0	0.00	0	0.00
Lost workday case illnesses involving days away from work <u>Total Col. 10 x 200,000</u> Rate = <u>Total Employee Hours</u>	0	0.00	0	0.00	0	0.00
Illnesses not involving lost workdays or restricted workdays <u>Total Col. 13 x 200,000</u> Rate = <u>Total Employee Hours</u>	0	0.00	0	0.00	0	0.00
Total OSHA Recordable Illness Rate <u>(Total Col. 8 + 9 + 13) x 200,000</u> Rate = <u>Total Employee Hours</u>	0	0.00	0	0.00	0	0.00
Total OSHA Recordable Injury/Illness Rate <u>(Total Col. 1 + 2 + 6 + 8 + 9 + 13) x 200,000</u> Rate = <u>Total Employee Hours</u>	4	0.87	4	0.90	3	0.69

27. Have you received any regulatory (EPA, OSHA, etc.) citations in the last three years?

If yes, please attach copies. Yes No

SAFETY & HEALTH MANAGEMENT

28. Highest ranking safety/health professional in the company: Lonnie Robisheaux

Title: Safety Director

Telephone: 361-884-6326

Fax: 361-884-9612

29. Do you have or provide:

- a. Full time Safety/Health Director Yes No
- b. Full time Site Safety/Health Supervisor Yes No
- c. Full Time Job Safety/Health Coordinator Yes No

30. Do you have or provide:

- a. Safety/Health incentive program Yes No
- b. Company paid safety/health training Yes No

SAFETY & HEALTH PROGRAMS & PROCEDURES

31. a. Do you have a written Safety and Health Program? Yes No
- b. Does the program address the following key elements?
1. Management commitment and expectations Yes No
 2. Employee participation Yes No
 3. Accountabilities and responsibilities for managers, supervisors, and employees Yes No
 4. Resources for meeting safety & health requirements Yes No
 5. Periodic safety and health performance appraisals for all employees Yes No
 6. Safety Recognition Program Yes No
 7. Hazard recognition and control Yes No
- c. Does the program satisfy your responsibility under the law for:
1. Ensuring your employees follow the safety rules of the facility? Yes No
 2. Advising owner of any unique hazards presented by the contractor's work, and of any hazards found by the contractor? Yes No

32. Does the program include work practices and procedures such as:

- | | | | | | | |
|--|-----|-------------------------------------|----|--------------------------|-----|-------------------------------------|
| a. Equipment Lockout and Tagout (LOTO) | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| b. Confined Space Entry | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| c. Injury & Illness Recording | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| d. Fall Protection | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| e. Personal Protective Equipment | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| f. Portable Electrical/Power Tools | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| g. Vehicle Safety | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| h. Compressed Gas Cylinders | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| i. Electrical Equipment Grounding Assurance | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| j. Powered Industrial Vehicles (Cranes, Forklifts, JLGs, etc.) | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| k. Housekeeping | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| l. Accident/Incident Reporting | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| m. Unsafe Condition Reporting | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| n. Emergency Preparedness, including evacuation plan | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |
| o. Waste Disposal | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input checked="" type="checkbox"/> |
| p. Back Injury Prevention | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> | N/A | <input type="checkbox"/> |

33. Do you have written programs for the following:						
a.	Hearing Conservation	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
b.	Respiratory Protection	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
	Where applicable, have employees been:					
	Trained	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
	Fit tested	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
	Medically approved	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
c.	Hazard Communication	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
	Have employees been trained	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
d.	Program to support the contractor requirements of the OSHA Process Safety Management of Highly Hazardous Chemicals; Explosives and Blasting Agents Standard (29 CFR 1910).	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
34. Do you have a substance abuse program? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
If yes, does it include the following?						
	• Pre-placement Testing	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
	• Random Testing	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
	• Testing for Cause	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
	• DOT Testing	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	
35. Do your employees read, write, and understand English such that they can perform their job tasks safely without an interpreter? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
If no, provide a description of your plan to assure that they can safely perform their jobs.						
36. Medical						
a.	Do you conduct medical examinations for:					
	• Pre-placement	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
	• Preplacement Job Capability	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
	• Hearing Function (Audiograms)	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
	• Pulmonary	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
	• Respiratory	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
b.	Describe how you will provide first aid and other medical services for your employees while on-site. Specify who will provide this service: <u>Onsite medical personnel or employee taken to company doctor</u>					
c.	Do you have personnel trained to perform first aid and CPR?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
37. Do you hold site safety and health meetings for:						
	Field Supervisors	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Frequency Weekly
	Employees	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Frequency Daily
	New Hires	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Frequency Daily and Weekly
	Subcontractors	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency N/A
	Are the safety and health meetings documented?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
38. Personal Protection Equipment (PPE)						
a.	Is applicable PPE provided for employees?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
b.	Do you have a program to assure that PPE is inspected and maintained?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
39. Do you have a corrective action process for addressing individual safety and health performance deficiencies?						
	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>		

40. Equipment and Materials:

a. Do you have a system for establishing applicable health, safety, and environmental specifications for acquisition of materials and equipment?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
b. Do you conduct inspections on operating equipment (e.g., cranes, forklifts, JLGs) in compliance with regulatory requirements?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
c. Do you maintain operating equipment in compliance with regulatory requirements?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
d. Do you maintain the applicable inspection and maintenance certification records for operating equipment?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>

41. Subcontractors

Do you use subcontractors? (If no, skip to question 43)

Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>		
a. Do you use safety and health performance criteria in selection of subcontractors?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
b. Do you evaluate the ability of subcontractors to comply with applicable health and safety requirements as part of the selection process?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
c. Do your subcontractors have a written Safety & Health Program?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
d. Do you include your subcontractors in:					
• Safety & Health Orientation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
• Safety & Health Meeting	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
• Inspections	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input checked="" type="checkbox"/>
• Audits	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input checked="" type="checkbox"/>

42. Inspections and Audits

a. Do you conduct safety and health inspections?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
b. Do you conduct safety and health program audits?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
c. Are corrections of deficiencies documented?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>

SAFETY & HEALTH TRAINING

43. Safety & Health Orientation

	<u>New Hires</u>				<u>Supervisors</u>			
a. Do you have a Safety & Health Orientation Program for new hires and newly hired or promoted supervisors?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
b. Does program provide instruction on the following:								
• New Worker Orientation	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Safe Work Practices	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Safety Supervision	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Toolbox Meetings	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Emergency Procedures	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• First Aid Procedures	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Incident Investigation	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Fire Protection and Prevention	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Safety Intervention	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
• Hazard Communication	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
c. How long is the orientation program? 1 Hours								
d. Are written exams given?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>				

If no, how do you verify comprehension?
(Written test, Craft Test, Performance Test, Job Monitoring, Other - List)

44. Safety & Health Training

- | | | | | |
|--|-----|-------------------------------------|----|--------------------------|
| a. Do you know the regulatory safety and health training requirements for your employees? | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> |
| b. Have your employees received the required safety and health training and retraining and is it documented? | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> |
| c. Do you have a specific safety and health training program for supervisors? | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> |
| d. Are all employees trained in the work practices needed to safely perform his/her job? | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> |
| e. Is each employee instructed in the known potential of fire, explosion, or toxic release hazards related to his/her job, the process and the applicable provisions of the emergency action plan? | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> |

INFORMATION SUBMITTAL

Please provide copies of checked (4) item with the completed PQF:

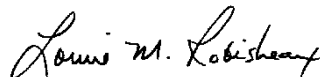
- EMR documentation from your insurance carrier
- Insurance Certificate(s)
- OSHA 300 Logs (Past 3 Years)
- Safety & Health Program
- Safety & Health Incentive Program
- Substance Abuse Program (Include Substances Tested & Levels)
- Hazard Communication Program
- Respiratory Protection Program
- Housekeeping Policy
- Accident/Incident Investigation Procedure
- Unsafe Condition Reporting Procedure
- Safety & Health Inspection Form
- Safety & Health Audit Procedure or Form
- Safety & Health Orientation (Outline)
- Safety & Health Training Program (Outline)
- Example of Employee Safety & Health Training Records
- Safety & Health Training Schedule (Sample)
- Safety & Health Training for Supervisors (Outline)

Attach a list of major equipment (e.g., cranes, JLGs, forklifts) your company has available for work at this facility and the method of establishing competency to operate.

Note: Owner checks items to be provided with PQF.

This document must be signed by a company officer.

Title Vice President/Safety
Name



Date 1/24/2015

PQF EVALUATION
-- OWNER USE ONLY --

DO NOT FILL OUT - OWNER USE ONLY

Contractor is:

Acceptable for Approved Contractor List

Conditionally acceptable for Approved Contractor List
Conditions:

Reviewer

Date: