

**Initial Audit Form**

The person responsible for the company safety programs should complete this form. The information provided will be used to determine what companies make it to the HSEA Finalist round of audits.

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| --- | --- | --- | --- | --- | --- |
| **General Information** | | | | | |
| **1. Company Name Click or tap here to enter text.** | | | **Phone Click or tap here to enter text.** | | |
| Company Address  Click or tap here to enter text. | | | | | |
| Primary Contact Name Click or tap here to enter text. | | | Title Click or tap here to enter text. | | |
| Phone Click or tap here to enter text. | | | | Email Click or tap here to enter text. | |
| Secondary Contact Name Click or tap here to enter text. | | | Title Click or tap here to enter text. | | |
| Phone Click or tap here to enter text. | | | | Email Click or tap here to enter text. | |
| **2. Parent Company (Optional) Click or tap here to enter text.** | | | | | |
| **Safety, Health & Environmental Performance** | | | | | |
| **3. Workers Compensation Experience Modification Rate (EMR) Data** | | | | | |
| a. EMR is Interstate Rate Monopolistic State Rate Dual Rate Not Required | | | | | |
| b. EMR for last three years  2019 EMR Click or tap here to enter text.  2020 EMR Click or tap here to enter text.  2021 EMR Click or tap here to enter text. | | | | | |
| c. State of Origin  Click or tap here to enter text. | | | | d. EMR Anniversary Date  Click or tap here to enter text. | |
| e. Standard Industrial Code (SIC) code North American Industry Classification Systems (NAICS) | | | | | |
| **4. Injury and Illness Data** | | | | | |
| a. Total company employee hours worked for the last three years (exclude subcontractors) | Hours/Year | 2019 | | 2020 | 2021 |
| Field | Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. |
| Total | Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. |
| b. Provide data (exclude subcontractors) using your OSHA 300 Forms from the past three years: Attach additional Word documents if necessary.  Click or tap here to enter text. | | | | | |
| (1) Data should be total company data unless specifically requested by the client.  (2) Combine injuries and illnesses as reported on 300 Form | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **(3) If your company is not required to maintain “OSHA 300” Forms, please provide information from your “Workers Compensation” insurance carrier itemizing all claims for the last three years.** | | **2019** | | **2020** | | | | **2021** | |
| **No.** | **Rate** | **No.** | **Rate** | | | **No.** | **Rate** |
| **Fatalities**  Rate = Number of fatalities x 200,000 ÷ Total Employee Hours | | **###** | **###** | **###** | **###** | | | **###** | **###** |
| **Lost workday case injuries and illnesses involving days away from work, or days of restricted work activity, or both.**  Rate = Total LW and restricted cases x 200,000 ÷ Total Employee hours | | **###** | **###** | **###** | **###** | | | **###** | **###** |
| **Lost workday case injuries and illnesses involving days away from work**  Rate = Total LW x 200,000 ÷ Total Employee hours | | **###** | **###** | **###** | **###** | | | **###** | **###** |
| **Injuries and Illnesses involving medical treatment only.**  Rate = Total Injuries and illnesses involving medical treatment only x 200,000 ÷ Total Employee Hours | | **###** | **###** | **###** | **###** | | | **###** | **###** |
| **Total OSHA Recordable Injury and Illness Rate**  Rate = Total Injuries and Illnesses x 200,000 ÷ Total Employee Hours | | **###** | **###** | **###** | **###** | | | **###** | **###** |
| **Has your company received any regulatory (EPA, OSHA, ect.), civil or criminal citations in the last three years?**  Yes  No If yes, please explain Click or tap here to enter text. | | | | | | | | | |
| **Information Submittal** | | | | | | | | | |
| Please provide copies of the checked items below along with this Initial Audit Form and the Safety Information Sheet. If any program is missing, you will score a “0” for that section. | | | | | | | | | |
|  |  | | | | |  | **Notes** | | |
|  | **1. Fatalities (this form)** | | | | |  |  | | |
|  | **2. OSHA Incidence of Lost Workday Rate (this form)** | | | | |  |  | | |
|  | **3. Total OSHA Recordable Injury and Illness (this form)** | | | | |  |  | | |
|  | **4. Regulatory Agency Citations for year 2021 (Use an additional page if necessary)** | | | | |  |  | | |
| **✓** | **5. Year to Year Improvement – Last three years** | | | | |  |  | | |
| **✓** | **6. Safety Goals** | | | | |  |  | | |
| **✓** | **7. Accident/ Incident Investigation Process** | | | | |  |  | | |
| **✓** | **8. Incident Lessons Learned** | | | | |  |  | | |
| **✓** | **9. Internal Audit / Assessment Program** | | | | |  |  | | |
| **✓** | **10. Contractor Orientation and HSE Training Program** | | | | |  |  | | |
| **✓** | **11. Environmental Program** | | | | |  |  | | |
| **✓** | **12. Industrial Hygiene Program** | | | | |  |  | | |
| **✓** | **13. Short Service Employee Program** | | | | |  |  | | |
| **✓** | **14. Behavioral Based Safety Program** | | | | |  |  | | |
| **✓** | **15. Contractor Written Employee Workforce Development Program** | | | | |  |  | | |
| **✓** | **16. Supervisor Training** | | | | |  |  | | |
| **✓** | **17. Brief description of your company’s top 3 “Best Practices”** | | | | |  |  | | |

**Type the name and title of the company officer responsible for assuring the accuracy of this document**

**Name:** Click or tap here to enter text. **Title:** Click or tap here to enter text. **Date:** Click or tap to enter a date.