

2019 Safety Awards Initial Evaluation Form

GENERAL INFORMATION					
1. Company Name:	Telephone:	Fax:			
Street Address:	Mailing Address:				
	Web site:				
Contact Person:	e-mail:				
Telephone:	Fax:				
2. Parent Company Name:					
SAFETY, HEALTH & ENVIRONMENTAL PERFORMANCE					
3. Workers Compensation Experience Modification Rate (EMR) Data					
a. EMR is <input type="checkbox"/> Interstate Rate <input type="checkbox"/> Intrastate Rate <input type="checkbox"/> Monopolistic State Rate <input type="checkbox"/> Dual rate <input type="checkbox"/> Not Required					
b. EMR for three last years:		YR: 2016	EMR:		
		YR: 2017	EMR:		
		YR: 2018	EMR:		
c. State of Origin:			d. EMR Anniversary Date:		
e. Standard Industrial Code (SIC):		North American Industry Classification Systems (NAICS)			
4. Injury and Illness Data:					
a. Total company employee hours worked last three years (excluding subcontractors)	Hours / Year	YR: 2016	YR: 2017	YR: 2018	
	Field				
	Total				
b. Provide data (excluding subcontractor) using your OSHA 300 Forms from the past three (3) years:					
Notes: (1) Data should be total company data unless specifically requested by 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 Worker's Compensation insurance carrier itemizing all claims for the last 3 years.		YR: 2016		YR: 2017	
		YR: 2018			
		No.	Rate	No.	Rate
		No.	Rate	No.	Rate
Fatalities <i>Rate = Number of Fatalities x 200,000 ÷ Total Employee Hours</i>					
Lost workday case injuries and illnesses involving days away from work, or days of restricted work activity, or both. <i>Rate = Total LW and restricted cases x 200,000 ÷ Total Employee Hours</i>					
Lost workday case injuries and illnesses involving days away from work. <i>Rate = LW cases** x 200,000 ÷ Total Employee Hours</i>					
Injuries and illnesses involving medical treatment only. <i>Rate = Total Injuries and Illnesses involving medical treatment only x 200,000 ÷ Total Employee Hours</i>					
Total OSHA Recordable Injury and Illnesses Rate <i>Rate = Total Injuries and Illnesses x 200,000 ÷ Total Employee Hours</i>					
Have you received any regulatory (EPA, OSHA, etc.), civil or criminal citations in the last three years? If yes, please explain Yes <input type="checkbox"/> No <input type="checkbox"/>					

INFORMATION SUBMITTAL

Please provide copies of checked items with this form and the 2019 Information Sheet

If program is missing, you will score a "0" for that category.

	1. Fatalities (Page 1 this Form)		
	2. OSHA Incidence of Lost Workday Rate (Page 1 this Form)		
	3. Total Record Injuries/Illnesses (Page 1 this Form)		
	4. Regulatory Agency Citations – For Year 2018 (Separate page if necessary)		
<input checked="" type="checkbox"/>	5. Year to Year Improvement – Last 3 Years		
<input checked="" type="checkbox"/>	6. Safety Goals		
<input checked="" type="checkbox"/>	7. Accident/Incident Investigation Process		
<input checked="" type="checkbox"/>	8. Incident Lesson Learned		
<input checked="" type="checkbox"/>	9. Internal Audit/Assessment Program		
<input checked="" type="checkbox"/>	10. Contractor Orientation and HSE Training Program		
<input checked="" type="checkbox"/>	11. Environmental Program		
<input checked="" type="checkbox"/>	12. Industrial Hygiene Program		
<input checked="" type="checkbox"/>	13. Short Service Employee Program		
<input checked="" type="checkbox"/>	14. Behavioral Based Safety Program		
<input checked="" type="checkbox"/>	15. Contractor Written Employee Workforce Development Program		
<input checked="" type="checkbox"/>	16. Supervisor Training		
<input checked="" type="checkbox"/>	17. Brief description of your company's Top 3 "Best Practices"		

Fill in below Name & Title of Company Officer responsible for assuring the accuracy of this document:

Name:

Title:

Date: