Confidential Subcontractor Qualification Questionnaire IH 635 LBJ East

The information you provide on this form will be treated as confidential by Pegasus Link Constructors (PLC) and will not be released to any other organization. Please answer all questions as completely as possible by using additional pages and attachments if necessary. If a question is not applicable to your company or business, write N/A in the space provided and give a brief explanation as to why that question does not apply. If a question does not apply and requires a numeric answer, please write "0" in the space provided.

This form cannot be filled out on line. Please print it out and fill in using either a typewriter or black ink. Email the completed questionnaire to: contracts@plclbj.com

To the Attention of:
Pegasus Link Constructors Procurement Dept.

If you have questions regarding any of the information requested on the questionnaire, please contact Procurement at – contracts@plclbj.com

A. Company

1. General Company Information:

Name: _____

Street Address:_____

Mailing Address:_____

Telephone Number: _____

Facsimile Number: _____

E-mail Address: _____

2. Primary person who will be responsible for the PLC account:

Name: _____

Title: _____

Telephone Number: _____

3. Secondary person who may be responsible for the PLC account:

Name: _____

Title: _____

Telephone Number: _____

4. How long has the organization been in business under the above name? _____

5. Is the organization a corporation, a partnership, or a sole proprietorship?

_____

6. If a corporation, in what state was the business incorporated? _____

7. If a sole proprietorship, list the owner and key personnel. If a partnership, list the general partners. If a corporation, list the principal officers:

NAME	TITLE

8. In what state(s) is the organization licensed and/or authorized to do business? List states licensed in, license number, active or inactive, license type, issuing agency, and principle license holder. Please include any transaction privilege, resale, or sales tax licenses as well as any and all subcontractor/professional licenses of any kind.

STATE	LICENSE NO.	ACTIVE/ INACTIVE	LICENSE TYPE	ISSUING AGENCY	PRINCIPLE HOLDER

9. Is the organization a subsidiary of, or affiliated with, another firm? **No** ☐ **Yes** ☐

   If yes, name of the other firm: _____

10. Is the organization presently operating under a trade name, D.B.A (doing business as), or AKA (also known as)? **No** ☐ **Yes** ☐

    If yes, enter the name(s): _____

11. Has the organization within the past 5 years operated under at D.B.A or AKA? **No** ☐ **Yes** ☐

    If yes, enter the name(s): _____

12. Is the organization's name registered or reserved with any agency in any states and/or countries in which it does business? **No** ☐ **Yes** ☐

    If yes, enter the states/countries: _____

    _____

13. Is the organization now in full compliance with current applicable Federal and/or State EEO laws and Executive Orders (please see http://www.eeoc.gov/)? If no, explain on a separate sheet. **N/A** ☐ **No** ☐ **Yes** ☐

14. Is the organization presently, or has it ever been certified as a Disadvantaged Business Enterprise (DBE) or Historically Underutilized Business (HUB)? If yes, please complete the following: **No** ☐ **Yes** ☐

    Certification: ☐SBE ☐DBE ☐MBE ☐WBE ☐HUB ☐Other_____

    Expiration Date of Certification: ____/____/____

    Certifying Agency:_____

    Ethnicity: ☐Anglo ☐Asian ☐Black ☐Hispanic ☐Native American ☐Other_____

    Gender**:** ☐Female ☐Male

15. Is the organization associated with any other subcontractor or company that performs work for PLC or its joint venture partners, Fluor Enterprises and Balfour Beatty Infrastructure? **No** ☐ **Yes** ☐

    If yes, state the name of the associated company and the relationship to that company:

    _____

16. Please provide a detailed list of the types of work in which the organization is routinely engaged.

17. Is the organization engaged in any other line of business? **No** ☐ **Yes** ☐

    If yes, please explain:_____

    _____

18. Is the organization a member of a Trade Association? **No** ☐ **Yes** ☐

    If yes, please specify: _____

B. Financial Status

1. Please attach a copy of the organization's audited financial statements and/or balance sheets for the past three years.

2. Please provide details of bank references:

NAME OF BANK	CONTACT NAME	TELEPHONE NUMBER

3. Federal Tax ID Number: _____

4. State Tax ID Number: _____

5. Dunn & Bradstreet No.: _____

6. Has the organization or any of its principals or officers, declared bankruptcy within the past 10 years? If yes, please explain on a separate sheet. **No** ☐ **Yes** ☐

7. Are there presently any judgments, suits, sanctions, debarments, or claims pending against, or contemplated by the organization that could negatively impact its ability to perform? If yes, please explain on a separate sheet. **No** ☐ **Yes** ☐

C. Turnover

1. What is the organization's average annual turnover for the past 5 years?

_____

2. What was the organization's turnover last year?

_____

D. Manpower

1. Total number of full time employees: _____

2. Please indicate the number of employees:

General Superintendents:	_____	Administrators:	_____
Accountants:	_____	Schedulers:	_____
Cost Engineers:	_____	Material Supervisors:	_____
Subcontract Supervisors:	_____	Quality Engineers:	_____
Expeditors:	_____	Field Engineers:	_____
Quantity Surveyors:	_____	Safety Officers:	_____
Lineman:	_____	Bricklayers:	_____
Pipefitters:	_____	Truck Drivers:	_____
Cement Finishers:	_____	Equipment Operators:	_____
Laborers:	_____	Electricians:	_____
Mechanics:	_____	Foreman:	_____
Carpenters:	_____	Civil Engineers:	_____
Reinforcing Steel Fixers:	_____	Instrument Fitters:	_____
Insulators:	_____	Painters:	_____
Scaffolding:	_____	Sheet Metal Workers:	_____
Welders:	_____	Erector Riggers:	_____
Structural Engineers:	_____	Mechanical Engineers:	_____
Piping Engineers:	_____	Electrical Engineers:	_____
Control System Engineers:	_____	_____:	_____
_____:	_____	_____:	_____

3. Indicate the organization's approach with respect to manpower resources:

	No	Yes
Work performed by own manpower?	☐	☐
Sub-tier Subcontract part of work to others?	☐	☐
Manpower/labor provider only?	☐	☐

4. Which type of work, if any, does the organization intend to sub-tier subcontract to others?

Description of work: _____

_____

_____

Indicate name(s) of potential sub-tier subcontractor(s) and work type: _____

_____

_____

5. Does the organization intend to perform the work in joint venture with another company? **No** ☐ **Yes** ☐

If yes, indicate name(s) of potential companies: _____

_____

6. Does the organization intend to perform the work as a sub-tier subcontractor for a main subcontractor? **No** ☐ **Yes** ☐

If yes, indicate name(s) of potential main sub-tier subcontractor(s): _____

_____

7. Does the organization supplement its own forces with personnel from other firms? If yes, specify the following: **No** ☐ **Yes** ☐

   Company Name: _____

   Address: _____

   Number of Personnel: _____ Date of Occurrence: _____/_____/_____

   On what basis: _____

8. Does the organization assign/hire out personnel to others? **No** ☐ **Yes** ☐

   If yes, specify on what basis:_____

E. Resources

1. Does the organization own any major equipment to be used for the proposed construction work? If yes, please attach a list including the item description, model, and year. **N/A** ☐ **No** ☐ **Yes** ☐

2. Does the organization have facilities for prefabrication at its shop? **N/A** ☐ **No** ☐ **Yes** ☐

3. Does the organization have facilities for prefabrication at the assembly yard? **N/A** ☐ **No** ☐ **Yes** ☐

4. Does the organization have adequate accessibility for transportation by water at its shop? **N/A** ☐ **No** ☐ **Yes** ☐

5. Does the organization have adequate accessibility for transportation by water at the assembly yard? **N/A** ☐ **No** ☐ **Yes** ☐

F. Current Workload

1. Indicate the magnitude of the organization's current workload, such as continued maintenance subcontracts, specific projects, etc.

DESCRIPTION OF SCOPE	VALUE	JOB DURATION

G. Future Workload

2. Indicate the magnitude of workload committed for the next two (2) years, such as continued maintenance subcontracts, specific projects, etc.

DESCRIPTION OF SCOPE	VALUE	JOB DURATION

H. Prior Work History

1. During the past year, how many jobs were completed by the organization? _____

DESCRIPTION OF SCOPE	VALUE	JOB DURATION

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. List three jobs the organization has completed in the past year that involved the type of services the organization proposes to provide to Fluor/ Balfour:

   Client Name: _____

   Contact Name: _____ Telephone: _____

   Job Location: _____

   Type of Work: _____

   Job Duration: _____

   Client Name: _____

   Contact Name: _____ Telephone: _____

   Job Location: _____

   Type of Work: _____

   Job Duration: _____

   Client Name: _____

   Contact Name: _____ Telephone: _____

   Job Location: _____

   Type of Work: _____

   Job Duration: _____

3. Has the organization ever failed to complete any work awarded to it? If yes, use separate sheet to explain where, why, and how the work was finally completed. **No** ☐ **Yes** ☐

I. References

1. List three Client/Customer references for work completed in the last three years:

CLIENT	PROJECT/LOCATION	TYPE OF WORK	YEAR	VALUE

2. List two business references other than the companies and individuals listed in item 1 above:

   Reference Name: _____ Telephone: _____

   Reference Name: _____ Telephone: _____

J. Quality Assurance

1. Does the organization have a published Quality Control/ Assurance Plan? **No** ☐ **Yes** ☐

2. Indicate the Quality Standard as applied by the organization: _____

3. Is the organization's Quality Control Plan ISO approved? (see http://www.iso.org) **No** ☐ **Yes** ☐

4. Is the organization's Quality System fully documented and available in writing? **No** ☐ **Yes** ☐

5. Is the organization's Quality System subject to independent 3rd party assessments? **No** ☐ **Yes** ☐

   If approved, please indicate name of the 3rd party: _____
   Please also include a copy of the Approval Certificate and Scope of Approval.

6. Is a Quality Control Manual implemented? **No** ☐ **Yes** ☐

   If the Quality System has not been independently approved (in reference to question 5 above, please include a copy of this manual.

7. Please provide the following for the organization's Quality Assurance Manager:

   Name: _____ Telephone: _____

8. Please indicate the number of full time employees trained in Quality Assurance: _____

K. Health, Safety, and Environmental

In general, the organization's HSE (Health, Safety and Environmental) performance for the last three years will be considered in this qualification evaluation with emphasis given to the most recent year's performance. Please refer to Attachment A for assistance in answering the following questions.

1. Does the organization have a published Safety Plan? **No** ☐ **Yes** ☐

2. Please provide the following for the organization's Safety Manager:

   Name: _____ Telephone: _____

3. Please indicate the number of full time employees trained in Safety: _____

4. For U.S. organizations, please list your organization's interstate or intrastate (if applicable) Experience Modification Rate (EMR) for the three most recent years, as evidenced in Workman's Compensation Insurance premiums:

Year:	Year:	Year:
Rate:	Rate:	Rate:

Please indicate if the above rates are:

☐ InTER-state/national average ☐ InTRA-state/provincal

Note: For the EMR to be satisfactory, the rate established by the National Council on Compensation Insurance (NCCI) or state rating bureau (if applicable) should be no greater than 1.2

For Non-U.S. organizations, if applicable, list your organization's Workers Compensation Board (WCB) discount/surcharge rate for the three most recent years. Please note the WCB discount/surcharge rates may not apply for locations where worker's compensation insurers or agencies do not produce these statistics. In this case, please substitute (and identify) a comparable performance metric if available:

Year:	Year:	Year:
Rate:	Rate:	Rate:

Note: To be acceptable, a WCB surcharge must not be more than 20% above the industry average. Higher rates may require a corrective action plan for the organization to be a qualified bidder. Please provide a copy of the letter from the organization's insurance broker or insurance company or WCB evidencing the rate for the last three years.

☐ Please check this box if the organization has less than the minimum number of employees required by law to carry workers' compensation insurance or if the organization does not have an EMR. If checked, please provide a letter from the organization's Insurance Company or WCB stating this.)

Is the organization self-insured for Workers Compensation claims? **No** ☐ **Yes** ☐

5. Fill in the following information for the last three available years. For US organizations, use its last three annual OSHA 200 or 300 Logs. For Non-US organizations, please see OSHA definitions at Attachment 1.

   Number and rate of Total (OSHA/BLS) Recordable Cases (In the U.S, total Col. 1, 2, 6, 8, 9, & 13 on OSHA 200 Log or Total Col. G, H, I, & J on OSHA 300 Log):

Year:	Year:	Year:
Number:	Number:	Number:
Rate:	Rate:	Rate:

Total number and rate of Restricted Work Activity Cases (In the U.S, subtract Col. 3 from Col. 2 & subtract Col. 10 from Col. 9 then add the two results together on OSHA 200 Log or Col. i on OSHA 300 Log):

Year:		Year:		Year:	
Number:		Number:		Number:	
Rate:		Rate:		Rate:	

Total number and rate of Days Away from Work Cases (In the U.S., Col. 3 & 10 on OSHA 200 Log or Col. H on OSHA 300 Log):

Year:		Year:		Year:	
Number:		Number:		Number:	
Rate:		Rate:		Rate:	

Total number and rate of Fatalities (Col. 1 & 8 on OSHA 200 Log or Col. G on OSHA 300 Log):

Year:		Year:		Year:	
Number:		Number:		Number:	
Rate:		Rate:		Rate:	

If the organization experienced a **work-related fatality** during this period, please attach a separate sheet with a brief description of the causes and corrective actions taken.

6. Total employee hours worked (do not include any non-work time, even though paid):

Year:		Year:		Year:	
Hours:		Hours:		Hours:	

7. List the organization's (OSHA/BLS) Total Recordable Incident Rate (TRIR) for the three most recent years. Calculate the organization's TRIR by counting without duplication all recordable injuries and illnesses. For U.S. organizations, multiply the organization's Total Recordable Cases by 200,000 and divide by the organization's total work hours for that calendar year.

Year:		Year:		Year:	
Rate:		Rate:		Rate:	

Note: To be satisfactory without corrective action, this rate should be less than 5.0.

Please attach a legible copy of the organization's most recent OSHA Log (or equivalent).

8. List the organization's Lost Workday Case Incident Rate (LWCIR) for the three most recent years, as evidenced by the organization's OSHA Log or equivalent document if non-U.S. Calculate the organization's LWCIR in the same manner as the TRIR, except use the Days Away from Work value rather than the Total Recordable Cases value.

Year:	Year:	Year:
Rate:	Rate:	Rate:

Note: To be satisfactory without corrective action, this rate should be no greater than 2.0.

Provide a legible copy of your most recent OSHA Log (or equivalent) with your submittal.

9. Please list any regulatory agency (e.g., OSHA, SH&S, EPA, OH&S, EC, state/ provincial agencies, etc.) safety or environmental citations or notices of violation, reportable spill events, sanitation code violations, or other governmental indications of an HSE incident received by the organization during the previous three years. HSE incident means an accident or some other unplanned event that causes or had potential to cause an injury, illness, environmental or property damage, or loss of production.

_____

_____

_____

_____

Please attach a copy of each or a summary describing the incident and how it was resolved.

10. Is the information collected from the OSHA logs/OH&S notices, HSE incident reports, and near miss reports communicated to the following? If yes, please indicate how often.

	No	**Monthly**	**Quarterly**	**Annually**
Field Superintendent or Department Mgr	☐	☐	☐	☐
Vice President	☐	☐	☐	☐
President or CEO	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

11. How are individual HSE incidents and associated costs recorded? If recorded, please indicate how often they are reported.

	No	Monthly	Quarterly	Annually
Incidents totaled for entire organization	☐	☐	☐	☐
Incidents totaled by project	☐	☐	☐	☐
Incidents subtotaled by superintendent or dept manager	☐	☐	☐	☐
Incidents subtotaled by foreman/supervisor	☐	☐	☐	☐
Costs totaled for entire organization	☐	☐	☐	☐
Costs totaled by project	☐	☐	☐	☐
Costs subtotaled by superintendent	☐	☐	☐	☐
Costs subtotaled by foreman/supervisor	☐	☐	☐	☐

12. Does the organization have a written HSE program? **No** ☐ **Yes** ☐

If yes, please attach a copy or a summary of the organization's program, including any HSE, safety, or environmental policy or mission statements the organization may have.

13. Does the organization have a Sustainability Program, Policy, or Report? If yes, please attach a brief summary. **No** ☐ **Yes** ☐

14. Does the organization have an orientation program for new hires? **No** ☐ **Yes** ☐

15. Does the organization have a program for newly hired or promoted foreman and supervisors? **No** ☐ **Yes** ☐

16. Please indicate below the elements included in the organization's overall HSE program, new hire training/orientation, and new supervisor/foreman training:

☐ Please check this box if no such programs exist:

Training	HSE Program	New Hire Training	Supervisor
Corporate HSE Policy	☐	☐	☐
HSE Workplace Committee	☐	☐	☐
HSE Inspections and Audits	☐	☐	☐
Personal Protective Equipment	☐	☐	☐
Hazard Assessment and Communication	☐	☐	☐
Task Assignment Training	☐	☐	☐

Respiratory Protection	☐	☐	☐
Fall Protection	☐	☐	☐
Scaffolding & Ladders	☐	☐	☐
Perimeter Guarding	☐	☐	☐
Housekeeping	☐	☐	☐
Fire Protection/Prevention	☐	☐	☐
First Aid Procedures/Facilities	☐	☐	☐
Emergency Procedures	☐	☐	☐
Toxic Substances/Hazard Communication	☐	☐	☐
Trenching & Excavation	☐	☐	☐
Signs, Barricades, & Flagging	☐	☐	☐
Electrical Safety	☐	☐	☐
Rigging & Crane Safety	☐	☐	☐
Safe Work Practices	☐	☐	☐
Safety Supervision	☐	☐	☐
Toolbox/Workplace HSE Meetings	☐	☐	☐
Incident Investigation/Reporting	☐	☐	☐
Confined Spaces	☐	☐	☐
Abrasive Blasting Safety	☐	☐	☐
Supervisor Training	**HSE Program**	**New Hire Training**	
Substance Abuse	☐	☐	☐
Vehicle Safety	☐	☐	☐
Use of Compressed Gas Cylinders	☐	☐	☐
Welding/Cutting	☐	☐	☐
Medical Evaluation	☐	☐	☐
Blood-borne Pathogens	☐	☐	☐
Employee Discipline	☐	☐	☐
High-pressure Water Cleaning	☐	☐	☐
Hot Taps	☐	☐	☐
Noise/Hearing Conservation	☐	☐	☐
Heat/Cold Stress	☐	☐	☐
Incentives/Awards for HSE Achievements	☐	☐	☐
Spill Prevention/Response	☐	☐	☐
Dust Suppression	☐	☐	☐
Wastewater/Storm Water Management	☐	☐	☐
Hazardous Waste & Solid Waste Management	☐	☐	☐
Equipment Emissions	☐	☐	☐

Wetlands/Sensitive Habitats	☐	☐	☐
Other _____	☐	☐	☐
Other _____	☐	☐	☐
Other _____	☐	☐	☐

Please attach a list of additional subjects if need be.

17. Does the organization hold workplace HSE meetings for supervisors? If yes, how often? **No** ☐ **Yes** ☐

Daily ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐ **As Needed** ☐

18. Does the organization hold employee “toolbox” HSE meetings? If yes, how often? **No** ☐ **Yes** ☐

Daily ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐ **As Needed** ☐

19. Does the organization conduct pre-task HSE planning meetings with employees? If yes, attach a brief description of the program format and/or attach a copy. **No** ☐ **Yes** ☐

20. Does the organization conduct workplace HSE inspections? **No** ☐ **Yes** ☐
If yes, who conducts this inspection? _____
How often is this inspection conducted?

Daily ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐ **As Needed** ☐

21. Is the organization a member of any external HSE program that awards certificates of recognition? **No** ☐ **Yes** ☐

If yes, please specify any certificates of recognition the organization has received within the past 3 years:

_____

22. Please identify the senior executive/manager directly responsible for the HSE program management and implementation at the organization:

    Name _____

    Title _____

    Reports to _____

L. Business Conduct and Ethics Expectations for Suppliers and Subcontractors

		No	Yes
1.	The organization has reviewed Fluor's "Business Conduct and Expectations for Suppliers and Subcontractors" on the Fluor website at http://www.fluor.com/sustainability/ethics_compliance and understands the requirements and expectations.	☐	☐
2.	The organization represents that its own policies regarding business conduct and ethics are aligned with the above "Business Conduct and Expectations for Suppliers and Subcontractors."	☐	☐
3.	Does the organization have its own written policies covering the above business conduct and ethics? If yes, please attach.	☐	☐
4.	Has the organization ever been found to be in violation by any court or governmental authority of any applicable anti-corruption and anti-bribery laws, including but not limited to the U.S. Foreign Corrupt Practices Act of 1977, as amended? If yes, please attach explanation.	☐	☐
5.	Is the organization under any investigation by any court or governmental authority with respect to alleged violations of any applicable anti-corruption and anti-bribery laws, including but not limited to the U.S. Foreign Corrupt Practices Act of 1977, as amended? If yes, please provide details in separate attachment.	☐	☐
6.	Is any owner, director, or officer of the organization (i) an officer or employee of a foreign government, agency, ministry, or instrumentality therefore, (ii) an officer or employee of a government-owned or controlled entity, (iii) an officer or employee of a public international organization, or (iv) an officer, employee or official of a foreign political party? If so, please provide details.	☐	☐

		No	Yes
7.	Is any immediate family member of an owner, director, or officer of the organization (i) an officer or employee of a foreign government, agency, ministry, or instrumentality therefore, (ii) an officer or employee of a government-owned or controlled entity, (iii) an officer or employee of a public international organization, or (iv) an officer, employee or official of a foreign political party? If so, please provide details.	☐	☐
8.	Does any officer or employee of a foreign government, agency, Ministry, or instrumentality thereof, officer, or employee of a government-owned or controlled entity, office or employee of a public international organization, or officer, employee or official of a foreign political party have any interest or stand to benefit in any way as a result of the organization's proposed agreement to work on the PLC project? If yes, please provide details.	☐	☐

M. Subcontractor Insurance Requirements

1. PLC requires its subcontractors to carry insurance coverage, per the following minimum limits:

Coverage	LIMITS
Worker's Compensation	USD 5,000,000 per Accident and for Bodily Injury by Disease, USD 5,000,000 per Employee
Commercial General Liability Insurance	General Aggregate Limit Not Less Than USD 5,000,000
Automobile Liability (any auto, owner, hired, non-owned)	Combined Single Limit USD 5,000,000 per Occurrence

The coverage limits specified in Commercial General Liability and Automobile Liability can be met by any combination of primary and excess liability insurance/umbrella policy.

Please check the appropriate box:
☐ The organization currently has in effect sufficient insurance to satisfy these requirements.

☐ The organization does not currently have in effect sufficient insurance to satisfy these requirements, but agree to meet these requirements in the event the organization meets all other qualifications required to do subcontract work for PLC.

2. Has the coverage indicated on the organization's present certificate of insurance been reduced by prior claims? **No** ☐ **Yes** ☐

3. Present Insurance Carrier: _____ Telephone: _____

N. Performance Guarantee

1. In the event the successful subcontractor is a subsidiary of another company, **PLC** may require a full performance guarantee from the parent or holding company for work performed by the successful bidder. Please provide, if applicable, the name and address of the parent or holding company willing to provide such performance guarantee.

   Name: _____

   Address: _____

2. What is your organization's bonding capacity? _____

3. Bonding Company Name: _____
   (Bonding assistance information is available upon request)

O. Subcontractor Qualification Signature

The Information presented here is accurate and complete to the best of my knowledge. Permission is hereby granted to PLC, its employees or agents, to make inquiries regarding the information herein provided.

Applicant Organization: _____

Print Name of Person Signing: _____

Signature of Person Signing: _____

Title: _____

Date: _____ Telephone: _____

ATTACHMENT A

U.S. Bureau of Labor Statistics/OSHA Recordkeeping Summary

This is a summary, prepared to assist the Subcontractor/sub-tier subcontractor in making Recordkeeping determinations to complete this form. For a more detailed explanation of the regulations the Subcontractor/sub-tier subcontractor is advised to review U.S. OSHA Regulation 29CFR1904, available on www.osha.gov

Basic recordkeeping concepts and guidelines are included with instructions on the back of U.S. OSHA Form No. 200. The following summarizes the major recordkeeping concepts and provides additional information to aid in keeping records accurately for both inside and outside the U.S.

General concepts of recordability

An injury or illness is considered work related if it results from an event of exposure in the work environment. The work environment is primarily composed of: (1) The employer's premises, and (2) other locations where employees are engaged in work-related activities or are present as a condition of their employment. **When an employee is off the employer's premises, work relationship must be established, when on the premises, this relationship is presumed.** The employer's premises encompass the total establishment. This includes not only the primary facility, but also such areas as company storage facilities, cafeterias, and rest rooms. In addition to physical locations, equipment or materials used in the course of an employee's work are also considered part of the employee's work environment.

Work relationship is not presumed when injury results as:

A. Member of general public
B. Eating, drinking one's own food
C Personal tasks outside working hours
D. Personal grooming or self-medication
E. Motor vehicle accident in parking lot
F. Cold or flu
G. Non-work related mental illness

All work-related fatalities are recordable.

All recognized or diagnosed work-related illnesses are recordable.

All work-related injuries requiring medical treatment or involving loss of consciousness, restriction of work or motion, or transfer to another job are recordable.

Analysis of Injuries

Recordable and nonrecordable injuries. Each case is distinguished by the treatment provided by a physician or licensed healthcare professional; i.e., if the injury was such that **medical treatment** was provided or should have been provided, it is recordable; if only first aid was required, it is not recordable. **However, medical treatment is only one of several criteria for determining recordability.** Regardless of treatment, if the injury involved loss of consciousness, restriction of work or motion, or transfer to another job, the injury is recordable.

Injuries & Illnesses. An injury or illness is an abnormal condition or disorder. Injuries include cases such as, but not limited to, a cut, fracture, sprain, or amputation. Illnesses include both acute and chronic illnesses, such as, but not limited to, a skin disease, respiratory disorder, or poisoning. (Note: Injuries and illnesses are recordable only if they are new, work-related cases that meet one or more of the OSHA Part 1904 Recording criteria.)

(RECORDABLE) Medical Treatment. The following procedures are generally considered medical treatment, Injuries for which this type of treatment was provided or should have been provided are almost always recordable if the injury IS work related:

* Treatment of **INFECTION**
* Hearing loss of 25 dBA from baseline

* Treatment of **SECOND OR THIRD DEGREE BURN(S)**
* Application of **SUTURES** (stitches)
* Removal of **FOREIGN BODIES EMBEDDED IN EYE**
* Removal of **FOREIGN BODIES FROM WOUND**; if procedure is **COMPLICATED** because of depth of embedment, size, or location
* Use of **PRESCRIPTION MEDICATIONS**
* Significant diagnosed injury – fracture; punctured eardrum; cancer; chronic irreversible disease
* **CUTTING AWAY DEAD SKIN** (surgical debridement)
* **POSITIVE X-RAY DIAGNOSIS** (fractures, broken bones, etc.)
* **ADMISSION TO A HOSPITAL** or equivalent medical facility **FOR TREATMENT.**

Medical Treatment DOES NOT include (a) visits to a physician or other licensed healthcare professional solely for observation or counseling; **(b)** diagnostic procedures such as x-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes (e.g., eye drops to dilate pupils); or **(c)** any treatment contained on the list of first-aid treatments.

(RECORDABLE) General Guidelines for recording Lost Workday Cases:

Count days lost from work **as prescribed** by the physician or licensed healthcare professional

Count calendar days

DO NOT count day of injury

(RECORDABLE) General Guidelines for recording Restricted Cases:

Cannot work a full shift.

Cannot perform all of his/her routine job functions (Routine = any duty regularly performed at least once per week)

First Aid Treatment. The following procedures are generally considered first aid treatment (e.g., one-time treatment and subsequent observation of minor injuries) and should not be recorded if the work-related injury does not involve loss of consciousness, restriction of work or motion, or transfer to another job. First Aid means only the following treatments (any treatment not included in this list is not considered **First Aid** for recordkeeping purposes):

* Using a non-prescription medication at non-prescription strength
* Administering tetanus immunizations
* Cleaning, flushing or soaking wounds on the surface of the skin
* Using wound coverages such as bandages, Band-Aids, gauze pads, etc.; or using butterfly bandages or Steri-Strips
* Using hot or cold therapy
* Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.
* Using temporary immobilization devices while transporting an accident victim
* Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister
* Using eye patches
* Removing foreign bodies from the eye using only irrigation or a cotton swab
* Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means
* Using finger guards
* Using massages
* Drinking fluids for relief of heat stress

The following procedure, by itself, is not considered medical treatment:

* Administration of **TETANUS SHOT(S)** or **BOOSTER(S)**. However, these shots are often given in conjunction with more serious injuries; consequently, injuries requiring these shots may be recordable for other reasons.

Reminder: Work-related injuries requiring only first aid treatment and do not involve any of the conditions in item 4 above, are not recordable.