M.P.G. Pipeline Contractors, LLC strives for the highest level of excellence by placing the safety of its employees and subcontractors as well as the surrounding public its number one priority. For this reason, M.P.G. Pipeline Contractors, LLC has implemented a Standardized Pre-Qualification Safety Questionnaire which is to be completed by all subcontractors that wish to perform services for our company. The Pre-Qualification information submitted will be reviewed and the results will be sent to you once the review process is complete. Failure to submit the required documentation may result in a delay in the review process or you being placed as an unapproved / disqualified subcontractor. Any questions relating to this Questionnaire can be addressed to Corey Butaud / HS&E Director at 713-955-9911 or emailed to cbutaud@mpg-plc.com.

Send the returned Questionnaire along with all required documents to:

M.P.G. Pipeline Contractors, LLC
16770 Imperial Valley, Suite 105
Houston, TX 77060
Attn: Corey Butaud / HS&E Director
or
Email to cbutaud@mpg-plc.com

Please provide the following information:

1. Completed Subcontractor Questionnaire

2. Copy of HS&E Manual along with any specific / specialized SOP's (Standard Operating Procedures) for services you wish to perform for M.P.G. Pipeline Contractors, LLC. This information will be kept on file and referenced as needed.

3. Copy of Workers Compensation Insurance Experience Modification Rating for the previous 3 years. This must be provided from your insurance carrier. We require verification of the EMR / discount rate information; see "Definition of Terms" for details.

4. Copy of OSHA 300 and 300 A logs for the previous 3 years. If your company is not required to complete OSHA 300 logs; provide copies of other appropriate industry related documentation.

HEALTH, SAFETY AND ENVIRONMENTAL SUBCONTRACTOR PRE-QUALIFICATION QUESTIONNAIRE

Date:		NAICS / SIC Code:	
Legal Company Name:		Company Phone #:	
Company Mailing Address:		City, State and Zip:	
Primary Company Contact:		Title of Primary Contact:	
Primary Contact Phone #:		Primary Contact E mail:	
Safety Contact:		Title of Safety Contact:	
Safety Contact Phone #:		Safety Contact Email:	
Form Completed By:		Title:	
Phone #:		E mail:	

*****The information requested must be for the local Division, District, Branch, etc. of the company. We are not interested in overall statistics at a national or international level. All information must be documented.*****

1. State the services your company wishes to provide for M.P.G. Pipeline Contractors, LLC:

____

____

2. In the table below, provide the previous 3 full years of incident information for your company. See "Definition of Terms" for details.

Year	Average Number of Employees	Exposure or Employee Hours	Medical Treatment Cases	Number of Lost Workday Cases	Number of Lost Workdays	Number of Restricted / Transferred Days Cases	Number of Restricted / Transferred Workdays	Total Recordable Incident Rate (TRIR)	Near Misses	First Aid Cases	Property / Equipment Damages	EMR	Number of Fatalities
20____													
20____													
20____													

3. Specify the basis for exposure or employee hours (8 hr. shifts, 10 hr. shifts, etc.) ____________________

4. Do you have a Fatigue Management Policy? Yes ❑ No ❑ **<u>**If so, provide copy with submittals**</u>**

5. Has your company had any inspections from a regulatory agency during the last 3 years?

   Yes ❑ No ❑ If yes, please provide details:____

   ____

6. Has your company received any citations from a regulatory agency during the last 3 years?

   Yes ❑ No ❑ If yes, please provide details:____

   ____

7. Are all documents pertaining to this questionnaire available for review? Yes ❑ No ❑

   If no, please explain:____

   ____

8. What is the name of the highest ranking safety professional in the company?____________________

Title:__________________ Telephone:_______________ Email: _____________________

9. Do you have or provide a:

a. Full time Health / Safety Director Yes ❑ No ❑

b. Jobsite Field Safety Personnel Yes ❑ No ❑

10. Do you have or provide:

a. Health / Safety Recognition program Yes ❑ No ❑

<u>If so, provide copy with submittals**</u>**

b. Company paid health / safety training Yes ❑ No ❑

11. Do you have a:

a. Written Health and Safety Program endorsed by Upper Management Yes ❑ No ❑

12. Does the written program address the following key elements?

a.	Management commitment and expectations	Yes ❑	No ❑
b.	Employee participation	Yes ❑	No ❑
c.	Accountabilities and Responsibilities for Managers, Supervisors / Foreman, and Employees	Yes ❑	No ❑
d.	Resources for meeting Health & Safety requirements	Yes ❑	No ❑
e.	Hazard Recognition and Control	Yes ❑	No ❑

13. Does the written program satisfy your responsibility under the law for:

a.	Ensuring your employees follow the safety rules of the client / contractor you are working for?	Yes ❑	No ❑
b.	Advising client / contractor of any unique hazards presented by your company's work, and of any hazards found?	Yes ❑	No ❑

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

a.	Equipment Lockout and Tagout (LOTO)	Yes❑	No❑	N/A❑
b.	Confined Space Entry	Yes❑	No❑	N/A❑
c.	Injury & Illness Recording	Yes❑	No❑	N/A❑
d.	Fall Protection	Yes❑	No❑	N/A❑
e.	Personal Protective Equipment	Yes❑	No❑	N/A❑
f.	Portable Electrical / Power Tools	Yes❑	No❑	N/A❑
g.	Vehicle / Driving Safety	Yes❑	No❑	N/A❑
h.	Compressed Gas Cylinders	Yes❑	No❑	N/A❑
i.	Electrical Equipment Grounding Assurance	Yes❑	No❑	N/A❑
j.	Powered Industrial Vehicles (Cranes, Forklifts, JLGs, etc.)	Yes❑	No❑	N/A❑
k.	Housekeeping	Yes❑	No❑	N/A❑

l.	Incident / Accident Reporting	Yes❑	No❑	N/A❑
m.	Stop Work Authority	Yes❑	No❑	N/A❑
n.	Emergency Preparedness, including Evacuation	Yes❑	No❑	N/A❑
o.	Waste Disposal	Yes❑	No❑	N/A❑
p.	Back Injury Prevention	Yes❑	No❑	N/A❑
q.	Trenching and Excavation	Yes❑	No❑	N/A❑
r.	Fire Protection and Prevention	Yes❑	No❑	N/A❑
s.	First Aid / CPR	Yes❑	No❑	N/A❑
t.	Hazard Communication	Yes❑	No❑	N/A❑
u.	Hearing Conservation	Yes❑	No❑	N/A❑
v.	Respiratory Protection	Yes❑	No❑	N/A❑
	Where applicable, have employees been:			
	Trained	Yes❑	No❑	
	Fit tested	Yes❑	No❑	
	Medically approved	Yes❑	No❑	
w.	Heat / Cold Stess Prevention	Yes❑	No❑	N/A❑
x.	Welding, Cutting, Hot Work	Yes❑	No❑	N/A❑
y.	Ladders	Yes❑	No❑	N/A❑

15. Do you have a written substance abuse program? Yes❑ No❑

a. If yes, does it include the following?

- Pre-Employment Testing Yes❑ No❑
- Random Testing Yes❑ No❑
- Testing for Cause Yes❑ No❑
- Post Accident Testing Yes❑ No❑
- Return to Duty Testing Yes❑ No❑

b. Does your drug testing program conform to DOT requirements? Yes ❑ No ❑

c. If yes, which set of DOT regulations are your drug testing program designed to satisfy?

*Federal Aviation Administration	Yes ❑	No ❑
*United States Coast Guard	Yes ❑	No ❑
*Pipeline and Hazardous Material Safety Adm. (PHMSA)	Yes ❑	No ❑
*Federal Railroad Administration	Yes ❑	No ❑
*Federal Highway Administration (FMCSA)	Yes ❑	No ❑

d. Has your drug testing program been audited by NCMS (National Compliance Management Services) Yes ❑ No ❑

16. Do your employees read, write, and understand English such that they can perform their job tasks safely without an interpreter? Yes ❑ No ❑

If no, provide a description of your plan to assure that they can safely perform their jobs.

____

____

17. Medical

a. Do you have personnel trained to perform First Aid and CPR? Yes ❑ No ❑

18. Heath and Safety Meetings

a. Do you hold jobsite health and safety meetings for:

Foreman / Supervisors Yes ❑ No ❑ Frequency:_______________________________

Employees Yes ❑ No ❑ Frequency:_______________________________

b. Are the Health and Safety meetings documented? Yes ❑ No ❑

Who conducts the safety meetings? Job Title:____

c. Are meetings reviewed and critiqued by managers? Yes ❑ No ❑

d. Does your company utilize a Job Safety Environmental Analysis (JSEA) or equivalent as part of your daily safety paperwork? Yes ❑ No ❑ **<u>**If so, provide copy with submittals**</u>**

19. Personal Protection Equipment (PPE)

a. Is applicable PPE provided for employees? Yes ❑ No ❑

b. Do you have a program to assure that PPE is inspected and maintained? Yes ❑ No ❑

20. Does your company provide / require the following Personal Protective Equipment:

		COMPANY PROVIDED	COMPANY REQUIRED
Hard Hats (ANSI-Z89.1)…………………………………	NA___	Yes___ No___	Yes___ No___
Safety Toe Footwear (ASTM F2413-05)…………..….	NA___	Yes___ No___	Yes___ No___
Eye Protection (ANSI-Z87.1)…………..……………..	NA___	Yes___ No___	Yes___ No___
Hand Protection ………………………………………..	NA___	Yes___ No___	Yes___ No___
Hearing Protection …….………………………………	NA___	Yes___ No___	Yes___ No___
Fall Protection………………………………......………..	NA___	Yes___ No___	Yes___ No___
Respiratory Protection……………………….……….	NA___	Yes___ No___	Yes___ No___
Personal Flotation Devices……………….…………...	NA___	Yes___ No___	Yes___ No___
Fire Retardant Clothing……………………..……….	NA___	Yes___ No___	Yes___ No___

21. Do you have a corrective action process for addressing individual Health and Safety performance deficiencies? Yes ❑ No ❑

If yes, please explain:____

____

22. Equipment and Materials:

a. Do you conduct inspections on operating equipment (e.g., cranes, forklifts, JLGs) in compliance with regulatory requirements? Yes❑ No❑ N/A❑

b. Do you maintain operating equipment in compliance with regulatory requirements? Yes❑ No❑ N/A❑

c. Do you maintain the applicable inspection and maintenance certification records for operating equipment? Yes❑ No❑ N/A❑

23. Inspections and Audits

a. Do you conduct Health and Safety inspections / audits? Yes ❑ No ❑

b. Who reviews the inspections / audits? ____

Comments:____

____

c. Are corrections of deficiencies documented? Yes ❑ No ❑

24. Health & Safety Orientation

	New Hire		**Foreman / Supervisors**	
a. Do you have a Health & Safety Orientation Program for New Hires and promoted Foremen / Supervisors?	Yes❑	No ❑	Yes ❑	No ❑

b. Does the program provide instruction on the following:

	New Hire		**Foreman / Supervisors**	
• New Worker Orientation	Yes ❑	No ❑	Yes ❑	No ❑
• Safe Work Practices	Yes ❑	No ❑	Yes ❑	No ❑
• Safety Supervision	Yes ❑	No ❑	Yes ❑	No ❑
• Toolbox Meetings	Yes ❑	No ❑	Yes ❑	No ❑
• Emergency Procedures	Yes ❑	No ❑	Yes ❑	No ❑
• First Aid Procedures	Yes ❑	No ❑	Yes ❑	No ❑
• Incident Investigation	Yes ❑	No ❑	Yes ❑	No ❑
• Fire Protection and Prevention	Yes ❑	No ❑	Yes ❑	No ❑
• Safety Intervention	Yes ❑	No ❑	Yes ❑	No ❑
• Hazard Communication	Yes ❑	No ❑	Yes ❑	No ❑

c. How long is the orientation program?____

d. Are written orientation comprehension exams given? Yes ❑ No ❑
If no, how do you verify comprehension?

____

____

e. Are refresher courses given? Yes ❑ No ❑ If so, how often? ________________________

25. Does your company have a written environmental management program? Yes ❑ No ❑
<u>If so, provide copy with submittals**</u>**

26. Health & Safety Training

a. Do you know the regulatory health and safety training requirements for your employees? Yes ❑ No ❑

b. Have your employees received the required health and safety training / retraining and is it documented? Yes ❑ No ❑

c. Do you have a specific health and safety training program for foreman / supervisors? Yes ❑ No ❑

d. Are all employees trained in the work practices needed to safely perform his / her job? Yes ❑ No ❑

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 ❑ No ❑

27. Does your company document, investigate, and discuss all incidents / accidents to include near misses? Yes ❑ No ❑

If yes, is documentation available? Yes ❑ No ❑

28. Are Incident / Accident reports reviewed by managers / management? Yes ❑ No ❑

29. Describe the programs utilized to monitor the safety performance of your company to determine progress (for example, management meetings, safety committee / team, statistical reports, etc.):

____

____

30. Do you have Operator Qualifed (OQ) employees? Yes ❑ No ❑
If yes, specify which organization they are qualified by:

Specify: ______Veriforce
______NCCER
______Other Specify:____

Having completed this Questionnaire, please state any adddtional comments you may have.

____

____

____

____

____

DEFINITION OF TERMS

Year
List the three previous calendar years.

Average Number of Employees
List the average number of employees 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, including working owners and officers.

Exposure or Employee Hours
List the total number of hours worked during the year by all employees, including those in but not limited to clerical, administrative, sales, etc.

Medical Treatment Cases
The management and care of a patient to combat disease or disorder as stated in Part 1904.

Number of Lost Work Day Cases
List the total number of lost work day cases that occurred during the year. A lost work day case will be defined as any recordable case that results in lost work days with days away from work.

Number of Lost Work Days
List the total number of lost work days experienced by all employees during the year.

Number of Restricted / Transferred Work Day Cases
List the total number of Restricted / Transferred cases that occurred during the year. A Restricted / Transferred Day case will be defined as any recordable case that results in Restricted / Transferred work days but does not result in death or days away.

Number of Restricted / Transferred Work Days
List the total number of Restricted / Transferred Work days experienced by all employees during the year.

(TRIR) Total Recordable Incident Rate = $\frac{\text{Number of all recordable cases X 200,000}}{\text{Exposure or employee hours}}$

Near Miss
A situation where no property was damaged and no personal injury sustained, but where given a slight shift in time and position, damage and/or injury could have easily occurred.

First Aid
For purposes of 1904, "First Aid" means the following:

- Using a non-prescription medication at nonprescription strength (for medications available in both prescription and non-prescription form, a recommendation by a physician or other licensed health care professional to use a non-prescription medication at prescription strength is considered medical treatment for recordkeeping purposes);

- Administering tetanus immunizations (other immunizations, such as Hepatitis B vaccine or rabies vaccine, are considered medical treatment);

- Cleaning, flushing or soaking wounds on the surface of the skin;

- Using wound coverings such as bandages, Band-Aids™, gauze pads, etc.; or using butterfly bandages or Steri-Strips™ (other wound closing devices such as sutures, staples, etc., are considered medical treatment);

- Using hot or cold therapy;

- Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc. (devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment for recordkeeping purposes);

- Using temporary immobilization devices while transporting an accident victim (***e.g.***, splints, slings, neck collars, back boards, etc.).

- 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 (physical therapy or chiropractic treatment are considered medical treatment for recordkeeping purposes); or
- Drinking fluids for relief of heat stress.

Property / Equipment Damage
Damage caused to company, contractor or client property / equipment.

EMR - 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 data listed above; or
- A copy of the last three years' Experience Rating Calculation Sheets, which your insurance carrier should forward to you annually; or
- A copy of the page of your last three years' insurance policies that show the modification rate and the coverage period

Number of Fatalities
List the total number of fatalities that result from occupational injuries or illnesses. Deaths, which occur in the workplace but are not the result of occupational injuries or illnesses, should not be included.

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