

**Central Michigan University**

**University Engineering and Planning**

**Pre Qualification Form (PQF)**

**For Contractors**

Please submit all Pre-Qualification Forms to:

Central Michigan University

University Engineering & Planning

Combined Services Building 206

Mt. Pleasant, MI 48859

***General Information***

\*Required fields must be filled out completely to be submitted for approval.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | \*Company Name: | | | | | | \*Telephone: | | | | \*Fax: |
|  | \*Street Address: | | | | | | \*Mailing Address: | | | | |
|  | | | | | | |  | | | | |
|  | | | | | | |  | | | | |
|  | | | | | | |  | | | | |
| \*Date: | | | | | | | E-Mail Address: | | | | |
| 1. | \*Officers  President:    Vice President:    Treasurer: | | | | | | | | | | |
| 2. | \*How many years has your organization been in business under your present firm name? | | | | | | | | | | |
| 3. | \*Parent Company Name: | | | | | | | | | | |
|  | City: | | | | State: | | | | Zip: | | |
| 4. | \*Under Current Management Since (Date): | | | | | | | | | | |
| 5. | \*Contact for Insurance Information: | | | | | | | | | | |
|  | Title: | | | | Telephone: | | | | Email: | | |
| 6. | \*Insurance Carrier(s) | | | | | | | | | | |
| Name | | | | Type of Coverage | | | | Telephone | | | |
|  | |  | | | |  | | | |  | |
|  | |  | | | |  | | | |  | |
|  | |  | | | |  | | | |  | |
| 7. | | \*Are you self-insured for Worker’s Compensation Insurance? Yes □ No □ | | | | | | | | | |
| 8. | | \*Contacts for Requesting Bids (list 2): | | | | | | | | | |
|  | | Name/Title: | | | | Telephone: | | | | Email: | |
|  | |  | | | |  | | | |  | |
| 9. | | \*Pre-Qualification Form completed By: | | | | | | | | | |
| Title: | | | Telephone: | | | | | Email: | | | |

***Organization***

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Form of Business: Sole Owner: □ Partnership: □ Corporation: □ | | | |
| 2. Describe Services Performed:  □ Construction □ Construction Design □ Original Equip. Manufacturer & Installer  □ Project Maintenance □ Maintenance □ Service Work (e.g. janitorial, clerical)  □ Other | | | |
| 3. Describe Additional Services Performed: | | | |
| 4. List other types of work within the services you normally perform that you subcontract to others: | | | |
| 5. 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: | | | |
| 6. Do you normally employ □ Union Personnel □ Non-Union Personnel  If union, list trades/locals: | | | |
| 7. Do you have or provide Company Paid Benefits – Please List: | | | |
| 8. Annual Dollar Volume for the Past Three Years: | | | |
| 20\_\_\_\_\_\_\_  $ | 20\_\_\_\_\_\_\_  $ | | 20\_\_\_\_\_\_\_  $ |
| 9. Largest Job During the Last 3 Years: $ | | | |
| 10. Your Firm’s Desired Project Size: | | | |
| Maximum: | | Minimum: | |
| 11. D & B Financial Rating: Current audited financial statement is requested. If not submitted with this package, CMU will require submission of this document before award of contracts $2,000,000 and greater. | | | |
| Annual Sales $ | | Net Worth $ | |
| 12. Bank Line of Credit (amt): | | Bank Reference(s): | |
| 13. Bonding Capacity: $ | | | |

***Work History***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Largest dollar valued jobs in progress: | | | | | | |
| Customer/Location | Type of Work | | Size - $M | Contact | | Telephone |
|  |  | |  |  | |  |
|  |  | |  |  | |  |
|  |  | |  |  | |  |
|  |  | |  |  | |  |
| 2. Largest dollar valued jobs in the past three years: | | | | | | |
| Customer/Location | Type of Work | | Size - $M | Contact | | Telephone |
|  |  | |  |  | |  |
|  |  | |  |  | |  |
|  |  | |  |  | |  |
|  |  | |  |  | |  |
| 3. Are there any judgements, claims or suits pending or outstanding against your company?    □ Yes □ No  If yes, please attach details | | | | | | |
| 4. Are you or have you ever been involved in any bankruptcy or reorganization proceedings?  □ Yes □ No  If yes, please attach details | | | | | | |
| 5. Has your organization ever failed to complete any work awarded to it? | | | | | | |
| 6. Has your organization been involved in any lawsuits or arbitration with regard to construction contracts within the last five years? | | | | | | |
| 7. Within the last five years, has any officer or principal of your organization ever been an officer or principal of another organization when it failed to complete a construction contract? (If the answer is yes, please attach details) | | | | | | |
| 8. Provide the following information on five owners that have used your services. Educational owners preferred. | | | | | | |
| **a)** Firm Name: | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| **b)** Firm Name: | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| **c)** Firm Name: | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| **d)** Firm Name | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| **e)** Firm Name | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| 9. Provide the following information on five architects that you have worked with in the past five years. Educational projects preferred. | | | | | | |
| **a)** Firm Name | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| **b)** Firm Name | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| **c)** Firm Name | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| **d)** Firm Name | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |
| **e)** Firm Name | | Contact Name: | | | Project: | |
| Address: | | Telephone: | | | Email: | |

***Safety and Health Performance***

|  |  |
| --- | --- |
| 1. Workers Compensation Experience Modification Rate (EMR) Data:  a) EMR is: b) EMR for last three years:  □ Interstate Rate \_\_\_\_\_\_\_\_ 20\_\_\_\_\_\_\_  □ Intrastate Rate \_\_\_\_\_\_\_\_ 20 \_\_\_\_\_\_\_  □ Monopolistic State Rate \_\_\_\_\_\_\_\_ 20 \_\_\_\_\_\_\_  □ Dual Rate  c) State or Origin: d) EMR Anniversary Date: | |
| 2. Injury and Illness Data:    **a)** Employee hours worked last three years (excluding subcontractors) | |
| Year: 20\_\_\_\_\_ | Hours: |
| Year: 20 \_\_\_\_ | Hours: |
| Year: 20 \_\_\_\_ | Hours: |
| **b)** Provide the following data (excluding subcontractor) using your OSHA 200 Forms for the past three (3) years: *(Notes: Data should be the best available data applicable to the work in this region or area. 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 three years).* | |
| Injury related fatality:  20\_\_ Number: Rate:  20\_\_ Number: Rate:  20\_\_ Number: Rate: | |
| Lost workday cases injuries involving days away from work, or days of restricted work activity or both:  20\_\_ Number: Rate:  20\_\_ Number: Rate:  20\_\_ Number: Rate: | |
| Lost workday case injuries involving days away from work:  20\_\_ Number: Rate:  20\_\_ Number: Rate:  20\_\_ Number: Rate: | |
| Injuries involving medical treatment only:  20\_\_ Number: Rate:  20\_\_ Number: Rate:  20\_\_ Number: Rate: | |
| Total OSHA Recordable Injury Rate:  20\_\_ Number: Rate:  20\_\_ Number: Rate:  20\_\_ Number: Rate: | |
| 3. Have you received any regulatory (EPA, OSHA, etc.) citations in the last three years?    Yes □ No □ | |

***Safety and Health Programs and Procedures***

|  |  |  |
| --- | --- | --- |
| 1. Highest ranking safety/health professional in the company: | | |
| Title: | Telephone: | Fax: |
| 2. Do you have or provide the following: | | |
| **a)** Full time Safety/Health Director. Yes □ No □ | | |
| **b)** Full time Safety/Health Supervisor: Yes □ No □ | | |
| **c)** Full time Job Safety/Health Coordinator: Yes □ No □ | | |
| 3. Do you have or provide the following: | | |
| **a)** Safety/Health incentive program: Yes □ No □ | | |
| **b)** Company paid safety/health training: Yes □ No □ | | |
| 4. Do you have a written Safety & Health Program? Yes □ No □  If yes, please submit | | |
| 5. Do you have a substance abuse program including Testing? Yes □ No □ | | |
| 6. 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. | | |

\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Firm Name/Principal

\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/Principal

\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Please submit all Pre-Qualification Forms to:

Central Michigan University

University Engineering & Planning

Combined Services Building 206

Mt. Pleasant, MI 48859

***Contractor Evaluation***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  | | --- | --- | --- | | DO NOT FILL OUT - OWNER USE ONLY | | | | The Contractor is: | | | | 🞎 | Acceptable for Approved Contractor List | | | 🞎 | Conditionally Acceptable for Approved Contractor List | | |  | Conditions:  Date Contractor Notified \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  .  Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |