



Standardized Pre-Qualification Form (PQF)

LCS CONSTRUCTORS, INC.

15205 Alton Parkway • Irvine • CA 92618

P 949.870-4500 • F 949.870-4501 • www.lcslab.com • CA License. #640058

GENERAL INFORMATION

1. Company Name:		Telephone:	Fax:
Street Address:		Mailing Address:	
		Web site:	
Contact Person:		e-mail:	
Telephone:		Fax:	
2. Officers		Years With Company	
President:			
Vice President:			
Treasurer:			
3. How many years has your organization been in business under your present firm name?			
4. Parent Company Name:		4b. Tax ID #:	
4a. Dun & Bradstreet #:			
City:	State:	Zip:	
Subsidiaries:			
5. Under Current Management Since (Date):			
6. Contact for Insurance Information:			
Title:	Telephone:	Fax:	
7. Insurance Carrier(s):			
Name	Type of Coverage	Telephone	
8. Are you self insured for Worker's Compensation Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>			
9. Contact for Requesting Bids:			
Title:	Telephone:	Fax:	
10. PQF Completed By:			
Title:	Telephone:	Fax:	



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ORGANIZATION

11. Form of Business: Sole Owner Partnership Corporation
 Date and State of Incorporation:

12. Percent Minority/Female Owned: _____ EEO Category: _____

13. A. Describe Services Performed: SIC Code:

<input type="checkbox"/> Construction	<input type="checkbox"/> Original Equipment Manufacturer and Maintenance
<input type="checkbox"/> Construction Design	<input type="checkbox"/> Service work (e.g., janitorial, clerical, etc.)
<input type="checkbox"/> Original Equipment Manufacturer and Installer	<input type="checkbox"/> Manpower and Resource
<input type="checkbox"/> Maintenance	<input type="checkbox"/> Other
<input type="checkbox"/> Specialty Maintenance	<input type="checkbox"/> Turnaround
	<input type="checkbox"/> Engineering

B. Work Categories - Check the categories in which you are interested in bidding and in which you are qualified to perform work. Feel free to attach additional information clarifying your capabilities and specialties.

"C" denotes work done by company employees

"S" denotes work done by subcontractors

C	S		C	S	
<input type="checkbox"/>	<input type="checkbox"/>	1. Air Conditioning/Refrigeration	<input type="checkbox"/>	<input type="checkbox"/>	11. Field Maintenance
<input type="checkbox"/>	<input type="checkbox"/>	Comfort Cooling/HVAC	<input type="checkbox"/>	<input type="checkbox"/>	General
<input type="checkbox"/>	<input type="checkbox"/>	Process Refrigeration	<input type="checkbox"/>	<input type="checkbox"/>	Hot Tap/line stops
		2. Buildings	<input type="checkbox"/>	<input type="checkbox"/>	Leak Sealing (online)
<input type="checkbox"/>	<input type="checkbox"/>	Remodeling	<input type="checkbox"/>	<input type="checkbox"/>	Field Machining
<input type="checkbox"/>	<input type="checkbox"/>	New (steel, brick, block, other)	<input type="checkbox"/>	<input type="checkbox"/>	Tank/Vessel Code
		3. Cleaning	<input type="checkbox"/>	<input type="checkbox"/>	Boiler Code
<input type="checkbox"/>	<input type="checkbox"/>	Industrial	<input type="checkbox"/>	<input type="checkbox"/>	Exchanger Retubing
<input type="checkbox"/>	<input type="checkbox"/>	Janitorial	<input type="checkbox"/>	<input type="checkbox"/>	Rotating Equipment
		4. Civil	<input type="checkbox"/>	<input type="checkbox"/>	Valve
<input type="checkbox"/>	<input type="checkbox"/>	Concrete	<input type="checkbox"/>	<input type="checkbox"/>	Cooling Tower
<input type="checkbox"/>	<input type="checkbox"/>	Excavation/Grading	<input type="checkbox"/>	<input type="checkbox"/>	High Alloy Welding (list type)
		Paving	<input type="checkbox"/>	<input type="checkbox"/>	Lead Lining
<input type="checkbox"/>	<input type="checkbox"/>	-- Asphalt	<input type="checkbox"/>	<input type="checkbox"/>	Glass Lining
<input type="checkbox"/>	<input type="checkbox"/>	-- Concrete	<input type="checkbox"/>	<input type="checkbox"/>	Heat Treating
<input type="checkbox"/>	<input type="checkbox"/>	5. Demolition/Dismantling	<input type="checkbox"/>	<input type="checkbox"/>	Nonmetallic materials
		6. Electrical	<input type="checkbox"/>	<input type="checkbox"/>	Pipe Fabrication
<input type="checkbox"/>	<input type="checkbox"/>	General	<input type="checkbox"/>	<input type="checkbox"/>	Mobil Equipment Repair
<input type="checkbox"/>	<input type="checkbox"/>	High-voltage/High-line	<input type="checkbox"/>	<input type="checkbox"/>	12. New Construction
<input type="checkbox"/>	<input type="checkbox"/>	Heat Tracing	<input type="checkbox"/>	<input type="checkbox"/>	13. Painting
<input type="checkbox"/>	<input type="checkbox"/>	Cathodic Protection			14. Refractory/Acid Brick
<input type="checkbox"/>	<input type="checkbox"/>	Grounding Systems	<input type="checkbox"/>	<input type="checkbox"/>	15. Rigging/Equipment Erection
		7. Inspection & Testing	<input type="checkbox"/>	<input type="checkbox"/>	16. Scaffolding
<input type="checkbox"/>	<input type="checkbox"/>	General NDT	<input type="checkbox"/>	<input type="checkbox"/>	17. Scale Maintenance
<input type="checkbox"/>	<input type="checkbox"/>	Infrared Scanning			18. Structural Steel Fab/Erection
<input type="checkbox"/>	<input type="checkbox"/>	Eddy Current Testing			19. Tanks - Field Erection
<input type="checkbox"/>	<input type="checkbox"/>	Acoustic Emission			20. Other
<input type="checkbox"/>	<input type="checkbox"/>	Column Scanning	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Civil/Soils			
<input type="checkbox"/>	<input type="checkbox"/>	High Voltage Electrical			
<input type="checkbox"/>	<input type="checkbox"/>	Electrical Ground Inspection			
<input type="checkbox"/>	<input type="checkbox"/>	Fiberglass Inspection			
<input type="checkbox"/>	<input type="checkbox"/>	Other			

Continued



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<p>8. Instrumentation</p> <p><input type="checkbox"/> <input type="checkbox"/> General <input type="checkbox"/> <input type="checkbox"/> DCS Control Systems</p> <p>9. Insulation</p> <p><input type="checkbox"/> <input type="checkbox"/> General <input type="checkbox"/> <input type="checkbox"/> Asbestos Abatement</p> <p>10. Linings/coatings for:</p> <p><input type="checkbox"/> <input type="checkbox"/> Metal <input type="checkbox"/> <input type="checkbox"/> Concrete</p>	<p>21. Consulting</p> <p><input type="checkbox"/> <input type="checkbox"/> - Mechanical <input type="checkbox"/> <input type="checkbox"/> - Electrical <input type="checkbox"/> <input type="checkbox"/> - Chemical <input type="checkbox"/> <input type="checkbox"/> - Metallurgical <input type="checkbox"/> <input type="checkbox"/> - Controls <input type="checkbox"/> <input type="checkbox"/> - Other</p>																						
<p>14. Describe Additional Services Performed:</p>																							
<p>15. List other types of work within the services you normally perform that you subcontract to others:</p>																							
<p>16. A. Do you normally employ? Union Personnel <input type="checkbox"/> Non-Union Personnel <input type="checkbox"/> Leased Personnel <input type="checkbox"/></p> <p>If union, list trades/locals:</p> <p>B. Average number of employees for last 3 years</p>																							
<p>17. Annual Dollar Volume for the Past 3 Years:</p>	<p>YR : 20_____</p> <p>\$ _____</p>	<p>YR :20 _____</p> <p>\$ _____</p>	<p>YR :20 _____</p> <p>\$ _____</p>																				
<p>18. Largest Job During the Last 3 Years:</p>																							
<p>19. Your Firm's Desired Project Size:</p>		<p>Maximum:</p>	<p>Minimum:</p>																				
<p>20. D&B Financial Rating:</p>	<p>Annual Sales</p>	<p>Net Worth: \$</p>																					
<p>21. Bank Line of Credit:</p>	<p>Bonding Capacity</p>	<p>Bank Reference(s):</p>																					
<p>22. Major jobs in progress:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Customer/Location</th> <th style="width:20%;">Type of Work</th> <th style="width:15%;">Size \$</th> <th style="width:20%;">Customer Contact</th> <th style="width:10%;">Telephone</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Customer/Location	Type of Work	Size \$	Customer Contact	Telephone															
Customer/Location	Type of Work	Size \$	Customer Contact	Telephone																			
<p>23. Major jobs completed in the past three years:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Customer/Location</th> <th style="width:20%;">Type of Work</th> <th style="width:15%;">Size \$</th> <th style="width:20%;">Customer Contact</th> <th style="width:10%;">Telephone</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Customer/Location	Type of Work	Size \$	Customer Contact	Telephone															
Customer/Location	Type of Work	Size \$	Customer Contact	Telephone																			
<p>24. Are there any judgments, claims or suits pending or outstanding against your company? If yes, please attach details. Yes <input type="checkbox"/> No <input type="checkbox"/></p>																							
<p>25. Are you now or have you ever been involved in any bankruptcy or reorganization proceedings? If yes, please attach details. Yes <input type="checkbox"/> No <input type="checkbox"/></p>																							



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SAFETY & HEALTH PERFORMANCE

26. Workers Compensation Experience Modification Rate (EMR) Data

a. EMR is:

Interstate rate

Intrastate rate

Monopolistic State rate

Dual rate

b. EMR for three last years:

2008: _____

2007: _____

2006: _____

c. State of Origin: _____

d. EMR Anniversary Date: _____

27. Injury and Illness Data:

a. Employee hours worked last three years (excluding subcontractors)

Hours / Year	YR 2008	YR 2007	YR 2006
Field			
Total			

b. Provide the following data (excluding subcontractor) using your OSHA 200 Forms from the past three (3) years:

Notes: (1) Data should be the best available data applicable to the work in this region or area.
 (2) 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 3 years)
 (3) if data is being provided after July 31st please include current YTD cumulative

Injury related fatality <i>Total Col. 1 x 200,000</i> Rate = Total Employee Hours	YR		YR		YR	
	No.	Rate	No.	Rate	No.	Rate
Lost workday case injuries involving days away from work, or days of restricted work activity, or both. <i>Total Col. 2 x 200,000</i> Rate = Total Employee Hours						
Lost workday case injuries involving days away from work. <i>Total Col. 3 x 200,000</i> Rate = Total Employee Hours						
Injuries involving medical treatment only. <i>Total Col. 6 x 200,000</i> Rate = Total Employee Hours						
Total OSHA Recordable Injury Rate <i>(Total Col. 1 + 2 + 6) x 200,000</i> Rate = Total Employee Hours						
Illness related fatality <i>Total Col. 8 x 200,000</i> Rate = Total Employee Hours						
Lost workday case illnesses involving days away from work, or days of restricted work activity, or both. <i>Total Col. 9 x 200,000</i> Rate = Total Employee Hours						
Lost workday case illnesses involving days away from work <i>Total Col. 10 x 200,000</i> Rate = Total Employee Hours						
Illnesses not involving lost workdays or restricted workdays <i>Total Col. 13 x 200,000</i> Rate = Total Employee Hours						
Total OSHA Recordable Illness Rate <i>(Total Col. 8 + 9 + 13) x 200,000</i> Rate = Total Employee Hours						
Total OSHA Recordable Injury/Illness Rate <i>(Total Col. 1 + 2 + 6 + 8 + 9 + 13) x 200,000</i> Rate = Total Employee Hours						



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28. Have you received any regulatory (EPA, OSHA, etc.) citations in the last three years?
If yes, please attach copies. Yes No

SAFETY & HEALTH MANAGEMENT

29. Highest ranking safety/health professional in the company: Title:

Contact: Telephone: Fax:

30. Do you have or provide:

- a. Full time Safety/Health Director Yes No
- b. Full time Site Safety/Health Supervisor Yes No
- c. Full Time Job Safety/Health Coordinator Yes No

31. Do you have or provide:

- a. Safety/Health incentive program Yes No
- b. Company paid safety/health training Yes No

SAFETY & HEALTH PROGRAMS & PROCEDURES

32. a. Do you have a written Safety and Health Program? Yes No

b. Does the program address the following key elements?

- 1. Management commitment and expectations Yes No
- 2. Employee participation Yes No
- 3. Accountabilities and responsibilities for managers, supervisors, and employees Yes No
- 4. Resources for meeting safety & health requirements Yes No
- 5. Periodic safety and health performance appraisals for all employees Yes No
- 6. Safety Recognition Program Yes No
- 7. Hazard recognition and control Yes No

c. Does the program satisfy your responsibility under the law for:

- 1. Ensuring your employees follow the safety rules of the facility? Yes No
- 2. Advising owner of any unique hazards presented by the contractor's work and of any hazards found by the contractor? Yes No

33. Does the 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 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. Accident/Incident Reporting Yes No N/A
- m. Unsafe Condition Reporting Yes No N/A
- n. Emergency Preparedness, including evacuation plan Yes No N/A
- o. Waste Disposal Yes No N/A
- p. Back Injury Prevention Yes No N/A



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34. Do you have written programs for the following:					
a. Hearing Conservation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
b. Respiratory Protection	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
Where applicable, have employees been:					
• Trained	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
• Fit tested	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
• Medically approved	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
c. Hazard Communication	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Have employees been trained	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
d. Program to support the contractor requirements of the OSHA Process Safety Management of Highly Hazardous Chemicals; Explosives and Blasting Agents Standard (29 CFR 1910).	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
35. Do you have a substance abuse program? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If yes, does it include the following?					
• Pre-placement Testing	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
• Random Testing	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
• Testing for Cause	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
• DOT Testing	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
• Post Incident Testing	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
36. Do your employees read, write, and understand English such that they can perform their job tasks safely without an interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If no, provide a description of your plan to assure that they can safely perform their jobs.					
37. Medical					
a. Do you conduct medical examinations for:					
• Pre-placement	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
• Preplacement Job Capability	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
• Hearing Function (Audiograms)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
• Pulmonary	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
• Respiratory	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A <input type="checkbox"/>
b. Describe how you will provide first aid and other medical services for your employees while on-site. _____ Specify who will provide this service: _____					
c. Do you have personnel trained to perform first aid and CPR? Yes <input type="checkbox"/> No <input type="checkbox"/>					
38. Do you hold site safety and health meetings for:					
Field Supervisors	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency
Employees	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency
New Hires	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency
Subcontractors	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Frequency
Are the safety and health meetings documented? Yes <input type="checkbox"/> No <input type="checkbox"/>					
39. Personal Protection Equipment (PPE)					
a. Is applicable PPE provided for employees? Yes <input type="checkbox"/> No <input type="checkbox"/>					
b. Do you have a program to assure that PPE is inspected and maintained? Yes <input type="checkbox"/> No <input type="checkbox"/>					
40. Do you have a corrective action process for addressing individual safety and health performance deficiencies? Yes <input type="checkbox"/> No <input type="checkbox"/>					



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41. Equipment and Materials:							
a.	Do you have a system for establishing applicable health, safety, and environmental specifications for acquisition of materials and equipment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
b.	Do you conduct inspections on operating equipment (e.g., cranes, forklifts, JLGs) in compliance with regulatory requirements?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
c.	Do you maintain operating equipment in compliance with regulatory requirements?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
d.	Do you maintain the applicable inspection and maintenance certification records for operating equipment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
42. Subcontractors							
	Do you use subcontractors? (If no, skip to question 43)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
a.	Do you use safety and health performance criteria in selection of subcontractors?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
b.	Do you evaluate the ability of subcontractors to comply with applicable health and safety requirements as part of the selection process?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
c.	Do your subcontractors have a written Safety & Health Program?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
d.	Do you include your subcontractors in:						
	• Safety & Health Orientation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
	• Safety & Health Meeting	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
	• Inspections	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
	• Audits	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
43. Inspections and Audits							
a.	Do you conduct safety and health inspections?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
b.	Do you conduct safety and health program audits?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
c.	Are corrections of deficiencies documented?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
44. N/A							
SAFETY & HEALTH TRAINING							
45. Safety & Health Training							
a.	Do you know the regulatory safety and health training requirements for your employees?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
b.	Have your employees received the required safety and health training and retraining and is it documented?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
c.	Do you have a specific safety and health training program for supervisors?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
d.	Are all employees trained in the work practices needed to safely perform his/her job?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
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	<input type="checkbox"/>	No	<input type="checkbox"/>		



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CRAFT TRAINING AND ASSESSMENT

Data as of: _____

Notes

1. Data should be the best available applicable to the workforce in this region or area
2. Skills Assessment means either the National Skills Assessment or the ISAC Skills Assessment. For other areas, if applicable, it would be the skills assessment process approved in the area.
3. Skill assessment is not required for helper/trainer/laborers or for craft employees who have either
 - 1) completed Wheels of Learning (WOL) or Department of Labor Bureau of Apprenticeship Training (DOL BAT) or
 - 2) are participating in WOL or DOL BAT.

46. WORKFORCE	Number	Percentage
a. Journeymen Craftsmen	_____	_____ %
b. Helper/Trainees	_____	_____ %
c. Total Workforce	_____	_____ %

47. TRAINING		
a. Do you have craft training records for employees?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. % of Craft Employees who have completed Wheels of Learning or DOL Bureau of Apprenticeship Training	_____ %	
c. % of Craft Employees presently enrolled in Wheels of Learning or DOL BAT	_____ %	
d. If employees have not completed or are not enrolled in Wheels of Learning or DOL BAT have they been trained in appropriate job skills (attach explanation)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

48. ASSESSMENT	Number	Percentage
a. Craftsmen who have been assessed through the craft skills assessment process (<i>see note 3</i>)	_____	_____ %
b. Craftsmen who have been assessed with "no deficiencies" identified	_____	_____ %
c. Craftsmen who have been assessed with training needs (WOL modules) identified	_____	_____ %
d. Craftsmen who have not been assessed through the skills assessment	_____	_____ %
e. Craftsmen assessed with training needs identified who have completed upgrade training	_____	_____ %
f. Where appropriate are training needs being addressed through skill upgrade training	Yes <input type="checkbox"/>	No <input type="checkbox"/>
g. For those employees for whom there is not a skills assessment available, do you have a process to assess the skills of your workers to assure they are qualified (<i>attach explanation</i>)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
1. Internal review of job performance yearly; 2. Training from senior craftsman; 3. Per project follow-up		
h. Are employees job skills certified where required by regulatory or industry consensus standards. (<i>attach a list of the crafts which have been certified</i>)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

49. HELPER/TRAINEEES	Number	Percentage
a. Helpers who are enrolled in Wheels of Learning or DOL Bureau of Apprenticeship Training	_____	_____ %
b. Helpers who are not enrolled in WOL or DOL BAT	_____	_____ %



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INFORMATION SUBMITTAL

Please provide copies of checked items with the completed PQF:

- EMR documentation from your insurance carrier
- Insurance Certificate(s)
- OSHA 300 Logs (Past 3 Years)
- Safety & Health Program (table of contents only)
- Safety & Health Incentive Program
- Substance Abuse Program (Include Substances Tested & Levels)
- Hazard Communication Program
- Respiratory Protection Program
- Housekeeping Policy
- Accident/Incident Investigation Procedure
- Unsafe Condition Reporting Procedure
- Safety & Health Inspection Form
- Safety & Health Audit Procedure or Form
- Safety & Health Orientation (Outline)
- Safety & Health Training Program (Outline)
- Example of Employee Safety & Health Training Records
- Safety & Health Training Schedule (Sample)
- Safety & Health Training for Supervisors (Outline)
- Organization Chart
- List of major equipment (e.g., cranes, JLGs, forklifts) your company has available for work at this facility.

Note: Owner checks items to be provided with PQF.

Items have been checked by LCS Constructors.

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

Title	Name	Date

PQF EVALUATION -- OWNER USE ONLY --

DO NOT FILL OUT - OWNER USE ONLY

Contractor is:

- Acceptable for Approved Contractor List
- Conditionally acceptable for Approved Contractor List
Conditions:

Reviewer

Date: