

**Instructions:** Please complete this form, attach requested supplemental documents, print as a PDF file, and submit to Mayo Clinic. Signature of the document can be completed through the Adobe signature function or by printing and signing a hard copy. If submitting electronically, submit distinctively named PDF files.

## Construction Contractor Qualification Form

Date: \_\_\_\_\_

Contractor's Legal Name: \_\_\_\_\_

Type of Contractor: \_\_\_\_\_

Primary Address: \_\_\_\_\_

Web Site: \_\_\_\_\_

Primary Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

1.) Provide license numbers for states where your firm is interested in doing Mayo Clinic work:

State/Location	Interested	License #/Federal Tax ID #
Mayo Clinic Florida		
Mayo Clinic Arizona		
Mayo Clinic Rochester		
Mayo Clinic Health System Southeast Minnesota		
Mayo Clinic Health System Southwest Minnesota		
Mayo Clinic Health System Northwest Wisconsin		
Mayo Clinic Health System Southwest Wisconsin		

2.) List the average number of directly employed contractor personnel by location support Mayo Clinic work over the last two years:

Branch Location (City/State)	# of Office Personnel	# of Field Supervision	# of Skilled Craftsmen	Total
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3.) Does your company qualify as any of the following classifications?

- |   |  |
|---|--|
| <input type="checkbox"/> Minority Owned Business Enterprise       | <input type="checkbox"/> Disadvantaged Business Owned Enterprise |
| <input type="checkbox"/> Women Owned Business Enterprise Minority | <input type="checkbox"/> Small Disadvantaged Business Enterprise |
| <input type="checkbox"/> Women Owned Business Enterprise          | <input type="checkbox"/> Hubzone                                 |
| <input type="checkbox"/> Veteran Owned Business Enterprise        | <input type="checkbox"/> Small Business Enterprise               |

4.) Does your company have a Workplace Diversity Program?  Yes  No

5.) Does your company have the ability to report 2<sup>nd</sup> Tier Targeted Business spend?  Yes  No

6.) Submit a separate .PDF file as a financial health metric. The statement or document must be authored by a certified accounting or financial institution. The following items must be included at a minimum:

- Identify your preferred credit agency (i.e. Dun and Bradstreet, Equifax), the rating of your company from that agency, and provide your organization’s ID number.
- Debt to Equity Ratio
- Current Ratio
- Profit Margin (%)

7.) Identify last year’s invoiced amount for performed work:

- Total (\$) invoiced for the previous calendar year: \_\_\_\_\_
- Mayo Clinic Projects amount (\$) invoiced for the previous calendar year: \_\_\_\_\_

8.) Indicate the approximate percentage of your contracted work that is self performed: \_\_\_\_\_

9.) Identify your firm’s three (3) largest customers based on total revenue.

<u>Name</u>	<u>Contact Name</u>	<u>Phone Number</u>
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____

10.) Identify any trade unions you have signatory agreements with:

<b>Name/Local #</b>	<b>Name/Local #</b>
• _____	_____
• _____	_____
• _____	_____
• _____	_____

11.) Has your firm been free of bankruptcy proceedings in the last five years?  Yes  No

12.) Does your firm have a written Quality Control program?  Yes  No

13.) Does your firm have a written Safety Program?  Yes  No

\*If yes, does that program include defined performance metrics?  Yes  No

\*\*If yes, please submit a PDF file of the table of contents (ONLY) of the program

14.) Does your firm have dedicated Safety personnel ; e.g. Director/Manager ?  Yes  No

15.) Are subcontractors pre-qualified and have documented Safety Programs  Yes  No

16.) Does your firm perform job-site safety audits?  Yes  No

\*If yes, describe frequency: \_\_\_\_\_

17.) Provide your firm’s “Experience Modification Ratio,” “OSHA Recordable Incident Rate,” and “Days Away, Restrictions, or Transfers (DART) Rate” for the past 3 years:

	2 years ago	1 year ago	Most Current
EMR			
Incident Rate			
DART			

18.) Provide copies of your OSHA 300 Log for the last two (2) years for states associated with your Mayo work.

19.) Is your firm proficient/competent at dealing with the following as it relates to your scope of work:

- Patient Care Environment  Yes  No
- Vivarium  Yes  No
- Firestopping  Yes  No
- Interim Life Safety Measures  Yes  No
- Infection Control  Yes  No
- Mold Awareness  Yes  No
- Lead Awareness  Yes  No
- Asbestos containing materials  Yes  No

20.) Check any of the following programs that currently exist at your company:

- Orientation program for new employees  Yes  No
- Trade specific skill training  Yes  No
- Trade specific code compliance training  Yes  No
- Technology training  Yes  No
- Background checks on all new hires  Yes  No
- Substance abuse & testing program for all employees  Yes  No
- Immunization program for all employees  Yes  No

***Document to be signed and affirmed by a company corporate officer.***

**Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_