|  |
| --- |
| CORPORATE INFORMATION |
| 1. Company Name:
 | Enter Text Here |
| 1. Contact:
 | Enter Text Here |
| 1. Mailing Address:
 | Enter Text Here |
| 1. Telephone No.:
 | Enter Text Here |
| 1. Email address:
 | Enter Text Here |
| 1. Website:
 | Enter Text Here |
| 1. Type of Business
 |  |  |  |
| [ ]  Partnership / Joint Venture | [ ]  Sole Owner | [ ]  Limited Company | [ ]  Corporation |
| 1. Country of Incorporation (if applicable): Enter Text Here
 | 1. Ownership Structure (% Guyanese): Enter Text Here
 |
| 1. Date of Establishment (if applicable): Enter Text Here
 | 1. Principal Line of Business/Services:

Enter Text Here |
| 1. Head Office and other Locations of Business (if applicable): Enter Text Here
 |
| 1. Are there any other names under which you have conducted business in the past ten (10) years?
 |
| OWNERSHIP |
| 1. Who are the principal officers of your organisation.
 |
| Name | Position | Years of Service |
| Enter Text Here | Enter Text Here | Enter Text Here |
| Enter Text Here | Enter Text Here | Enter Text Here |
| Enter Text Here | Enter Text Here | Enter Text Here |
| Enter Text Here | Enter Text Here | Enter Text Here |
| 1. Please state how many employees your business has (at your head office and overall)
 | Number of employees:  |  |
| FINANCIAL INFORMATION |
| 1. Approximate turnover/revenue in the last five (5) years:
 |
| [ ]  Less than $0.5 million (U.S.) | [ ]  $1 - $2 million (U.S.) | [ ]  $2 - $5 million (U.S.) | [ ]  Over $5 million (U.S.) |
| 1. If your company is a new venture, estimated turnover/revenue for the next business year: Enter Text Here
 |
| 1. Briefly describe the nature of your business. Please include details about any memberships, accreditations, industry groups or registrations such as Chamber of Commerce.

Enter Text Here |
| 1. Have you declared bankruptcy or changed majority ownership in the last five (5) years?

[ ]  Yes [ ]  NoComments:Enter Text Here |
| INSURANCE INFORMATION |
| To prepare a Due Diligence report on the project including a review of the AA) a) Insurance CarrierEnter Text Here1. Type of Coverage

Enter Text Here1. Are you self-insured for Workers Compensation Insurance?

[ ]  Yes [ ]  No |
| QUALITY MANAGEMENT SYSTEM, POLICY & PROCEDURES |
| 1. Does the company have a Quality Policy?

[ ]  Yes [ ]  No |
| 1. Does the company have a Quality Manager?

[ ]  Yes [ ]  NoComments:Enter Text Here |
| 1. Does the company have a Quality Manual?

[ ]  Yes [ ]  NoComments:Enter Text Here |
| HEALTH, SAFETY & ENVIRONMENT PROGRAM (HSE) |
| 1. Do you have a documented HSE Program? If yes, please attached a copy of the Program.

[ ]  Yes [ ]  No |
| 1. If your company is certified; provide the following details of your HSE Management System:
 |
| Certificate No.: | System Standard.: | Issued By: | Renewal Date: |
| 1. Outline why safety is important to your company and describe senior management’s involvement in your company’s Safety, Health & Environment program.

Enter Text Here |
| 1. Describe how your company encourages workers to be involved in safety programs and be accountable for safety results.

Enter Text Here |
| 1. Describe how your company co-ordinates and manages working interfaces between workers and subcontractors on site. Include a description of how compliance to safety procedures is monitored.

Enter Text Here |
| 1. If your company is not certified; do you have a specific plan to have your systems certified?

[ ]  Yes [ ]  NoComments:Enter Text Here |
| 1. Your company must be able to comply with BCQS’s Health & Safety Guidelines (attached).

 Please confirm[ ]  Yes [ ]  No |
| 1. Please provide a copy of your company’s Alcohol and Drugs (A&D) policy.

Provide details if your company’s Alcohol and Drugs policy includes:* Pre-placement testing.
* Random testing.
* Post-incident testing and testing for cause.

Enter Text Here   |
| 1. Would your company be willing to meet ExxonMobil’s A&D policy requirements?

[ ]  Yes [ ]  No |
| 1. Your company must be able to comply with BCQS’s Drug and Alcohol testing policy (attached).

Please confirm[ ]  Yes [ ]  No |
| 1. Note: All staff working on specific projects will require background checks.
 |
| 1. i) Provide details / data of your injury record for the last full 3 years as per table.

 Objective is to assess your safety performance against BCQS & ExxonMobil expectations and in-country/market standards).

|  |  |  |
| --- | --- | --- |
| Year: | Year: | Year: |
| Number of Cases | Number of Cases | Number of Cases |
| Injury Related Fatality - Employees |  |  |  |
| Employee occupational injuries resulting in lost time |  |  |  |
| Employee occupational injuries resulting in medical treatment. (beyond First Aid Treatment) |  |  |  |
| Approximate employee total Work Hours per Year |  |  |  |
| List the total number of fatalities that result from occupational injuries or illnesses. Deaths that occur in the workplace but are not the result of occupational injuries should not be included |

sub-contractor, etc.): |
| 1. Has your company received any citations from regulatory agencies during the last three (3) years?

 Provide copies. |
| 1. Describe your company’s Safety, Health & Environment training and orientation program and provide details on specific trade or craft training. Describe how this is managed and documented and provide examples of the types of training included in your program.

Enter Text Here |
|  |
| REFERENCES |
| 1. List three references (persons/companies familiar with you/your company – financial institution, supplier, sub-contractor, etc.):
 |
| **Reference 1** | Company: | Enter Text Here |
| Contact Name and Title: | Enter Text Here |
| Address: | Enter Text Here |
| Email Address: | Enter Text Here |
| Telephone Nos.: | Enter Text Here |
| Background on Relationship (including number of years working together): | Enter Text Here |
|  |
| **Reference 2** | Company: | Enter Text Here |
| Contact Name and Title: | Enter Text Here |
| Address: | Enter Text Here |
| Email Address: | Enter Text Here |
| Telephone Nos.: | Enter Text Here |
| Background on Relationship (including number of years working together): | Enter Text Here |
| **Reference 3** | Company: | Enter Text Here |
| Contact Name and Title: | Enter Text Here |
| Address: | Enter Text Here |
| Email Address.: | Enter Text Here |
| Telephone Nos.: | Enter Text Here |
| Background on Relationship (including number of years working together): |  |
| PAYMENT TERMS |
| 1. Payment Terms are strictly 60 days from receipt of invoice by the Client. Please confirm this is acceptable.

[ ]  Yes [ ]  No |
| COMPANY OPERATIONS |
| 1. Do you plan to use any other entities or individuals, including subsidiaries, affiliates, partnerships or joint ventures, consultants, intermediaries or any other individuals other than your own employees to perform services under the proposed agreement? If yes, can you identify their names and address, their relationship to you, and the activities they will perform.

[ ]  Yes [ ]  NoEnter Text Here |
| 1. List type of work your company normally sub-contracts to others.

Enter Text Here |
|  |

|  |  |  |
| --- | --- | --- |
| **Authorised person:** |  | **Signature:** |
| **Title:** |  |  |
| **Date:** |  |  |