Subcontractor Prequalification Application

Fax the completed questionnaire to 504.327.5840

All subcontractors are required to supply the following information to assist us in evaluating your firm's qualification as an approved subcontractor for Associated Drywall Partners. The contents of this questionnaire will be considered confidential and used solely to determine your firm's qualification.

General Information

PLEASE NOTE : QUESTIONNAIRES MUST BE FILLED OUT COMPLETELY, MISSING INFORMATION MAY RESULT IN DISQUALIFICATION FOR CONSIDERATION

Name of Business _____

Owners Name _____

Street Address _____

City, State, Zip Code _____

Primary Contact _____

Phone Number _____

Cell Phone Number _____

Fax Number _____

Email Address _____

Organization Information

Organization Type

Sole Proprietorship Partnership Limited Liability Company Corporation

If a Partnership, LLC or Corp what state was the company organized in? _____

Federal Tax ID # _____

Is your firm owned or controlled by any other organization/s? _____

Number of Employees _____

Information About Your Work

What type of work does your company perform?

Metal Framing --- Years of Experience with Metal Framing _____

Hanging Drywall --- Years of Experience Hanging _____

Finishing Drywall --- Years of Experience Finishing _____

Painting --- Years of Experience Painting _____

Scrapping --- Years of Experience Scrapping _____

Repairs --- Years of Experience with Repairs _____

Number of People on a Crew _____

Number of Crews _____

Please List at Least 3 Jobs You Have Completed in the Last 2 Years

Project Name Location Completion Date Gen Contractor Contact Name & Phone

Are there any judgments, claims, arbitrations, proceedings or suits pending/outstanding againstyour company or its officers or principals?

( ) Yes ( )No

If yes please explain _____
_____

Has your company filed any liens, lawsuits or requested arbitration or mediation with regard to work performed?

( )Yes ( ) No

If yes please explain _____
_____

Safety

Do you have a safety program?

_____

Pease obtain your Workers Comp EMR (Experience Modification Ratings) from your Workers Comp carrier for the past three years.

Last year _____ Year before last _____ 3 years ago _____

Insurance

Do you currently carry or can you obtain the following insurance coverage?

Workers Compensation Yes No

What state/s do you have Workers Comp coverage in? _____

General Liability $1,000,000 Yes No

Insurance Company:

Insurance Agent's Name:

Insurance Agent's Address:

Insurance Agent's Phone Number:

This questionnaire was completed by:

Printed Name: _____

Title: _____

Signature: _____

Date: _____