

Initial Audit Form (IAF)



The person responsible for the company safety programs should complete this form. The information provided will be used to determine what companies make it to the Safety Excellence Awards Finalist round of the process.

GENERAL INFORMATION										
1. Company Name: Click or tap here to enter text.				: Click or tap here to enter text.						
Company Address:										
Click or tap here to enter	text.									
· · · · · · · · · · · · · · · · · · ·										
Primary Contact Name:	Click or tap here to	enter text.	Title: Cl	ick or tap l	here to enter text.					
Phone: Click or tap here to enter text.					Email: Click or tap here to enter text.					
Secondary Contact Name: Click or tap here to enter text.					Title: Click or tap here to enter text.					
Phone: Click or tap here to enter text.				Email: Click or tap here to enter text.						
2. Parent Company (Opti	ional) Click or tap	here to enter t	ext.							
	SAFETY, HEA	LTH & ENV	IRONM	ENTAL	PERFORMANCE					
3. Workers Compensation										
a. EMR is: Intersta	ate Rate	opolistic State Ra	ite 🗆 🗆	Dual Rate	□Not Required					
b. EMR for the last three	=									
		D22 EMR Click o								
		D23 EMR Click o								
	20	D24 EMR Click of	or tap her							
c. State of Origin: Click or tap here to enter text.				d. EMR Anniversary Date: Click or tap here to enter text.						
			rth American Industry Classification Systems (NAICS)							
4. Injury and Illness Data					, ,					
a. Total company employee hours	Year	2022			2023	2024				
worked for the last three years (exclude subcontractors)	Field Hours	Click or tap henter te		Click or	tap here to enter text.	Click or tap here to enter text.				
	Total Hours	Click or tap h enter te		Click or	tap here to enter text.	Click or tap here to enter text.				
Provide the	data (excluding su	bcontractors) u	sing your	OSHA 30	0 Forms from the pa	st three years.				
	otal company data	· ·		ed otherwi	ise.					

If your company is not required to maintain "OSHA 300" Forms, please provide information from your "Workers

Compensation" insurance carrier itemizing all claims for the last three years.



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Recordkeeping Data	2022		2023		2024		
	No.	Rate	No.	Rate	No.	Rate	
Fatalities							
Rate = Number of fatalities x 200,000 ÷ total	###	###	###	###	###	###	
employee hours							
Day away from work, Restricted duty, or							
Transfer (DART)	###	###	###	###	###	###	
Rate = Total DART x 200,000 ÷ total employee hours							
Lost workday case - injuries and illnesses							
involving days away from work.			###	###	###	###	
Rate = Total LWD x 200,000 ÷ total employee	###	###					
hours							
Injuries and Illnesses involving medical							
treatment only.		###	###	###	###	###	
Rate = Total Injuries and illnesses involving	###						
medical treatment only x 200,000 ÷ total							
employee hours							
Total OSHA Recordable Injury and Illness		###	###		###	###	
Rate Rate = Total Injuries and Illnesses x 200,000 ÷	###			###			
total employee hours							
Has your company received any regulatory (EPA	i, OSHA, etc.)	, civil or crimi	nal citations i	n the last thre	e years?		
☐ Yes ☐ No If yes, please explain (Click or tap h	ere to enter	text.				
IN	FORMAT	ION SUBM	IITTAL				
Please provide copies of the checked item	s below alor	ng with this In	itial Audit Fo	rm and the S	afety Informa	ation Sheet.	
If any program is missing, you will score a		_					
					Notes		
1. Fatalities (this form)							
2. OSHA Incidence of Lost Workday Rate (this form)							
3. Total OSHA Recordable Injury and Illness (this form)							
4. Regulatory Agency Citations for the	year 2024 (Use additional	page(s) if ne	cessary)			
✓ 5. Year-to-Year Improvement – Last th							
✓ 6. Safety Goals							
	7. Accident/ Incident Investigation Process						
✓ 8. Incident Lessons Learned							
✓ 9. Internal Audit / Assessment Program							
✓ 10. Contractor Orientation and HSE Tra							
✓ 11. Environmental Program							
✓ 12. Industrial Hygiene Program		11. Livii Olinicitai i Togram					
✓ 13. Short Service Employee Program	121 maddin myglene i rogiam						
✓ 14. Behavioral Based Safety Program	kforce Deve	lonment Pro	gram				
 ✓ 14. Behavioral Based Safety Program ✓ 15. Contractor Written Employee Work 	kforce Deve	lopment Pro	gram				
✓ 14. Behavioral Based Safety Program		•	gram				

Below, type the name and title of the company officer responsible for assuring the accuracy of this document.

Name: Click or tap here to enter text. Title: Click or tap here to enter text. Date: Click or tap to enter a date.