

LANGAN Subcontractor Information Form (Canada)

1. Company Information				
Company Name: _____			Tax Identification Number (TIN) #: _____	
Mailing Address: _____				
City: _____		Providence/Territory: _____		Postal Code: _____
Phone: _____		Web Site: _____		
2. General Information				
2.1 North American Industry Classification Code (NAICS): _____		2.2 In which Providence/Territory do you do business? _____		
2.3 Type of work: _____				
3. Health & Safety Program				
3.1 Identify person directly responsible for the Health & Safety Program at your company.				
Name: _____			Title: _____	
Email: _____		Phone: _____		
3.2 Workers Compensation Employer Premium Rate: Provide below information: Providence/Territory: _____; Industry Code: _____; WCB Number: _____ Rate for the last three years: 2025/ _____ 2024/ _____ 2023/ _____ <input type="checkbox"/> Do not have an Employer Premium Rate.				
3.3 Summary of Incidents / Injuries: Provide the following data regarding illnesses and injuries. (If maintained, information can be taken from Workers Compensation Board (WCB) logs.) Are logs for work-related injuries/illnesses maintained for company? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Number of Incident / Injuries that resulted in:	2025	2024	2023	Current YTD
Number of Fatalities	_____	_____	_____	_____
Number of Lost Time injuries/illnesses	_____	_____	_____	_____
Number of Days Away from Work	_____	_____	_____	_____
Number of Modified Work Injuries	_____	_____	_____	_____
Number of Modified Workdays	_____	_____	_____	_____
Number of Medical Aid Injuries	_____	_____	_____	_____
Number of First Aid Injuries	_____	_____	_____	_____
Lost Time Incident Rate	_____	_____	_____	_____
WCB Recordable Incident Rate	_____	_____	_____	_____
Total Number of Recordable Incidents	_____	_____	_____	_____
Total Employee Hours Worked	_____	_____	_____	_____
3.4 Do you have a written Health & Safety Program?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.5 Do you conduct health and safety inspections?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are the inspections documented			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are deficiencies and corrections documented?			Yes <input type="checkbox"/>	No <input type="checkbox"/>

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3.6 Do your employees have documented training in the following:

- | | | | |
|--------------------------|------------------------------|-----------------------------|------------------|
| • WHMIS | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How Often: _____ |
| • Respiratory Protection | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How Often: _____ |
| • PPE | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How Often: _____ |
| • Hearing Conservation | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How Often: _____ |
| • Confined Space Entry | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How Often: _____ |
| • Fall Protection | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How Often: _____ |
| • Scaffolding | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How Often: _____ |
| • Excavations | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How Often: _____ |

3.7 Have you received any regulatory (CCOHS, Ministry of Labour, CEPA, etc.), civil or criminal citations in the last three years?

Yes No

3.8 Do you hold site health and safety meetings for employees: Yes No

If "Yes", are the meetings held: Daily Weekly Monthly Other: _____

Are the meetings documented? Yes No

3.9 Do you have a substance abuse program? Yes No

If yes, indicate whether it includes the following:

- | | | |
|--------------------------|------------------------------|-----------------------------|
| • Pre-employment 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"/> |
| • Post-Accident Testing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • DOT Testing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

4. Additional Documentation Required – Provide copies of the following:

- WCB Logs - for the last 3 years;
- Employer Premium Rate documentation from your insurance carrier for the last 3 years; and
- Copies of any regulatory (CCOHS, Ministry of Labour, CEPA, etc.) civil or criminal citations that occurred in the last three years or a summary describing the incident(s) and how it was resolved.

5. Certification

I certify, to the best of my knowledge, the information provided above is accurate and correct.

Name: _____

Signature: _____

Date: _____

Phone: _____

Completed form is to be faxed or emailed to the attention of:

*Ken Bloom, CSP, SMP, ASP, Health & Safety Manager;
Langan 2700 Kelly Rd. Suite 200, Warrington, PA 18976
Phone: (215) 491-6500; Fax: (215) 491-6501; Email: kbloom@langan.com*