

INSTRUCTIONS:



FLEET

To complete the "Application For Driver Qualification" form, please complete the information requested below which will automatically distribute throughout the form:

Today's Date:

First Name:

Middle Name:

Last Name:

Email:

Cell Phone Area Code:

Cell Phone Number:

Home Phone Area Code:

Home Phone Number:

Birth Month:

Birth Day:

Birth Year:

Social Security Number:

Home Address:

Home City:

Home State:

Home Zip:

Driver's License #:

Driver's License State:

Driver's License Type: (usually CDL)

Expiration Date:

PRE-EMPLOYMENT ADVISORY - DRIVER

1. Fleet Personnel Corp. (Fleet Personnel Corp.) is a corporation authorized to conduct business in the state of Alabama and all normal business operations are conducted in the state of Alabama. All employees are hired and employed through the Russellville, AL office.
2. All Fleet Personnel Corp.'s contracts and agreements are made in Alabama. Control, direction and administration of any matter regarding day to day operations of business activities are done in, and pursuant to the laws and regulations of the state of Alabama. Any disputes shall be governed by Alabama law with venue being Franklin County Alabama .
3. Fleet Personnel Corp.'s unemployment compensation is provided in accordance with the laws of the state of Fleet Personnel Corp.'s client company.
4. Because of the nature of work required, you could be performing work in states other than Alabama. Any disputes concerning Fleet Personnel Corp.'s Workers Compensation covering on the job injuries in other states will be provided under the laws of Alabama with Alabama entitlements. Compensation entitlements will be based on federal taxable wages. Misrepresentations as to preexisting physical or mental conditions may void your workers' compensation benefits. All employees are subject to a drug test after a job-related injury. Employees must report any injury directly to Fleet Personnel Corp. within 24 hours of occurrence.
5. Employees of Fleet Personnel Corp. are financially responsible for the costs of follow-up drug and alcohol tests after a positive result.
6. Fleet Personnel Corp.'s responsibility for withholding of federal and state taxes is in accordance with federal and applicable state laws.
7. Employees of Fleet Personnel Corp. that participate in the per diem program understand that contributions to Federal Tax, State Tax, Workmen's Compensation, and Social Security may be proportionately reduced.
8. Because of the nature of work required, you will be assigned to perform such work at places other than Fleet Personnel Corp., premises such as: on the road, in other places of business, industry, or places where there are other employees of other companies, in or out of the state of Alabama, and wherein you will perform your job alongside, with, and among employees of other companies.
9. Fleet Personnel Corp. will send or assign you hourly, daily, weekly, or monthly, on a temporary, part-time, or dedicated basis to work at other companies' (other than Fleet Personnel Corp.'s) place of business. While working at such other companies or places, you may be required to obey and conform to reasonable rules, regulations, and orders of supervisors from such other companies. If you become dissatisfied with your current work, you should contact Fleet Personnel Corp. at once for other job opportunities.
10. Employees of Fleet Personnel Corp. become eligible for voluntary benefits beginning the 1st of the month after 90 days of employment. It is the responsibility of the employee to notify Fleet Personnel Corp. if he/she wishes to participate in any voluntary benefits.

After reading the above, should you wish to make application to Fleet Personnel Corp. for employment, please sign this advisory, which acknowledges your understanding and acceptance of Fleet Personnel Corp. positions outlined above.

Upon receipt of signed advisory, an application will be furnished. When completed, application will be processed and applicant notified if acceptable. At such time, applicant will complete hiring process, and will become an employee of Fleet Personnel Corp. under a ninety (90) day probationary period.

Signature of Applicant

Date

Witness

Fleet

Commercial Driver Job Description

JOB TITLE: Commercial Truck Driver

GENERAL STATEMENT OF DUTIES: Operate 26,000+ lb. trucks on interstate and/or intrastate routes; arrange, load, transport and unload freight.

SUPERVISION RECEIVED: Limited -- receive schedule and routing directions from assigned carrier's dispatcher.

SUPERVISION EXERCISED: None.

ESSENTIAL FUNCTIONS:

1. Operate large commercial motor vehicles for extended periods of time in all environmental conditions, often functioning in new geographic areas and in congested traffic situations.
2. Arranges, loads and unloads freight of various weights, sizes and shapes received from customers and/or other shippers and consignees.
3. Communicates with assigned carrier dispatcher, customers and others involved in freight movements regarding specifics of commodities being transported, locations and time frames for pick-ups and deliveries.
4. Maintains records for compliance with D.O.T. and other applicable regulatory requirements.
5. Assesses operating condition of commercial motor vehicles and performs minor vehicle repairs.

MINIMUM QUALIFICATIONS:

1. Must possess valid commercial drivers license and an acceptable commercial vehicle driving history (e.g., experience, number of citations, number of "chargeable" accidents).
2. Must meet all other D.O.T. qualification criteria for commercial truck drivers, as detailed in Federal Motor Carrier Safety Regulations, including physical qualification criteria and substance abuse testing requirements.
3. Must possess capable driving skills and ability to safely operate 26,000+ vehicles in broad range of road, weather and traffic conditions.
4. Ability to read, understand and interpret traffic signage and roadside instructions.
5. Must be able to deal with customers and/or other shippers and consignees, and the public, with tact and effectiveness.

SPECIFIC JOB DEMANDS:

<u>Activity</u>	<u>Frequency*</u>
1. Sitting	Continually
2. Walking	Occasionally
3. Standing	Occasionally
4. Bending	Occasionally
5. Squatting	Occasionally
6. Climbing	Occasionally
7. Kneeling	Occasionally
8. Twisting body	Frequently
9. Hand use	
a. Simple grasping	Constantly
b. Power grasping	Frequently
c. Push and pull	Occasionally
d. Fine manipulation	Constantly
10. Use of feet to operate controls	Constantly
11. Reading	
a. Above the shoulder	Frequently
b. Below the shoulder	Constantly
12. Lifting	Frequently (typical weights -- up to 70 pounds)
13. Carrying	Frequently (typical weights -- up to 70 pounds)
14. Visual requirements	
a. Low light	Frequently
b. Near vision	Constantly
c. Far vision	Constantly
d. Depth perception	Constantly
e. Lateral vision	Constantly
15. Auditory requirements	
a. Hear signals	Constantly
b. Hear radio	Constantly
c. Routine communications	Occasionally
16. Other Applicable Working Conditions (check if applicable)	
_____ Walking near hazardous machinery	
_____ Walking on uneven ground	
_____ Exposure to dust, fumes, gases, chemicals	
_____ Exposure to noise	
_____ Exposure to extremes of temperature or humidity	
_____ Working at heights	
_____ Working at high altitudes	
_____ Other hazards (specify) _____	

*/ Frequency classifications are as follows: occasionally (0 to 1/3 of the workday); frequently (1/3 to 2/3 of the workday); and continually (2/3 to 3/3 of the workday).

I fully understand the job description described above and I have no health restrictions or previous injuries that would keep me from performing these job duties.

Signed _____

Date _____

II. EMPLOYMENT RECORD FOR PAST 10 YEARS

Begin with your present or most recent job and work backward in order, listing your employer for at least 10 years including all full-time and part-time employment. All time must be accounted for including military service, self-employment and periods of unemployment. Use supplementary sheet if necessary. We must have telephone numbers!

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Current Or Most Recent Employer: Name _____ Contact Person _____

Are you presently employed? Yes _____ No _____ May we call your current employer? Yes _____ No _____

Address _____ Telephone (_____) _____

Position Held _____ Date From _____ To _____ Rate of Pay _____

Why do you want to change employers? _____ # of States Driven in _____

of Accidents _____ # of Worker's Comp Claims? _____ Please Explain _____

Were you subject to the FMCSRs while employed? Yes _____ No _____ Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the Drug and Alcohol testing requirements of 49 CFR Part 40? Yes _____ No _____

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Second Last Employer: Name _____ Contact Person _____

Address _____ Telephone (_____) _____

Position Held _____ Date From _____ To _____ Rate of Pay _____

Reason for Leaving? _____ # of States Driven in _____

of Accidents _____ # of Worker's Comp Claims? _____ Please Explain _____

Were you subject to the FMCSRs while employed? Yes _____ No _____ Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the Drug and Alcohol testing requirements of 49 CFR Part 40? Yes _____ No _____

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Third Last Employer: Name _____ Contact Person _____

Address _____ Telephone (_____) _____

Position Held _____ Date From _____ To _____ Rate of Pay _____

Reason for Leaving? _____ # of States Driven in _____

of Accidents _____ # of Worker's Comp Claims? _____ Please Explain _____

Were you subject to the FMCSRs while employed? Yes _____ No _____ Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the Drug and Alcohol testing requirements of 49 CFR Part 40? Yes _____ No _____

=====

Fourth Last Employer: Name _____ Contact Person _____

Address _____ Telephone (_____) _____

Position Held _____ Date From _____ To _____ Rate of Pay _____

Reason for Leaving? _____ # of States Driven in _____

of Accidents _____ # of Worker's Comp Claims? _____ Please Explain _____

Were you subject to the FMCSRs while employed? Yes _____ No _____ Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the Drug and Alcohol testing requirements of 49 CFR Part 40? Yes _____ No _____

=====

Fifth Last Employer: Name _____ Contact Person _____

Address _____ Telephone (_____) _____

Position Held _____ Date From _____ To _____ Rate of Pay _____

Reason for Leaving? _____ # of States Driven in _____

of Accidents _____ # of Worker's Comp Claims? _____ Please Explain _____

Were you subject to the FMCSRs while employed? Yes _____ No _____ Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the Drug and Alcohol testing requirements of 49 CFR Part 40? Yes _____ No _____

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Sixth Last Employer: Name _____ Contact Person _____

Address _____ Telephone (_____) _____

Position Held _____ Date From _____ To _____ Rate of Pay _____

Reason for Leaving? _____ # of States Driven in _____

of Accidents _____ # of Worker's Comp Claims? _____ Please Explain _____

Were you subject to the FMCSRs while employed? Yes _____ No _____ Was your job designated as a safety-sensitive function in any DOT-Regulated mode subject to the Drug and Alcohol testing requirements of 49 CFR Part 40? Yes _____ No _____

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III. DRIVING RECORD/EXPERIENCE

LICENSE

List ALL drivers licenses/permits held in the past

<i>State</i>	<i>License Number</i>	<i>Type</i>	<i>Expiration Date</i>

Check Endorsements that you have: Combinations Hazardous Materials Air Brakes

TRAFFIC CONVICTIONS/FORFEITURES

List ALL vehicle moving traffic convictions and forfeitures for the past three years (IF NONE, WRITE NONE)

<i>Date</i>	<i>Location (State)</i>	<i>Charge</i>	<i>Penalty</i>

ACCIDENT RECORD

List ALL accidents/incidents with vehicles for past three years, include preventable and non-preventable, whether or not on MVR.

(IF NONE, WRITE NONE)

<i>Date</i>	<i>Type of Vehicle</i>	<i>Nature of Accident (Head-on, Rear-end, etc.)</i>	<i>Preventable</i>		<i>Fatalities</i>		<i>Injuries</i>		<i>Amount of Property Damage</i>
			Yes	No	Yes	No	Yes	No	

NATURE AND EXTENT OF EXPERIENCE

<i>Type</i>	<i>Trailer Length</i>	<i>Years of Experience</i>	<i>Approx Number of Miles</i>	<i>States Operated In</i>
Tractor with Flatbed				
Tractor with Van				
Tractor with Reefer				
Tractor with Tank				
Straight Truck				
Dump Truck				
Other (Specify)				

Show special courses or training that will help you as a Driver: _____

Which safe Driving awards do you hold and from whom? _____

- A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? ___ Yes ___ No
- B. Have you ever had any license, permit or privilege suspended or revoked? ___ Yes ___ No
- C. Have you ever been convicted for driving while under the influence of alcohol or drugs? ___ Yes ___ No
- D. Have you ever been convicted for possession, sale, or use of a narcotic drug, amphetamine, or derivative thereof? ___ Yes ___ No
- E. Have you ever been refused liability insurance? ___ Yes ___ No
- F. Have you ever been convicted of a Felony? ___ Yes ___ No
- G. Have you ever been convicted of a Misdemeanor? ___ Yes ___ No
- H. Have you ever been disqualified to drive by Federal Regulations? ___ Yes ___ No
- I. Have you ever been refused a security bond? ___ Yes ___ No

If you answered "Yes" to any question A through I, please give details: _____

IV. EDUCATIONAL BACKGROUND

Type of School	Name and City/State	Graduated?	Years Attended	Major?
Grade		___ Yes ___ No		
High School		___ Yes ___ No		
College		___ Yes ___ No		
Graduate		___ Yes ___ No		
Trade School		___ Yes ___ No		
Driving School		___ Yes ___ No	Graduation Date:	

V. MILITARY STATUS

Have you served in the U.S. Armed Forces? _____ Branch? _____ Dates: From _____ to _____

DD214 Narrative reason for discharge: _____

Honorable Discharge? ___ Yes ___ No Any Medical Disability as a result of service? ___ Yes ___ No

VI. AGREEMENT

TO BE READ AND SIGNED BY APPLICANT

This application for qualification and any resulting contract of hire, shall be deemed to be completed and executed in the state of Alabama. All questions of law and fact which may arise regarding this application, or regarding any aspect of any employment relationship between me and Fleet, will be interpreted, determined, and resolved in accordance with the laws of the State of Alabama, Franklin County regardless of where I or my residence may be located at the time of hire or at any time during the course of my employment. It is agreed and understood if employed, that any misrepresentations or false information by applicant shall be considered fraudulent and may subject applicant to immediate discharge.

It is agreed and understood that Fleet or motor carrier or their agents may investigate the applicant’s background to ascertain any and all information of concern to applicant’s record, whether same is of record or not, and applicant released former and/or current employers named herein from all liability for any damages for furnishing such information. It is understood that the information in this application will be used and that prior employers will be contacted for purposes of investigations and inquires as required by the motor carrier safety regulation, 390.15 and 391.23 .I understand that under regulation 391.23 I have the right to (1) review the information provided by previous employers (2) To have errors corrected (3) Submit a rebuttal statement (4) Request must be made in writing to review previous employer provided information.

I agree to voluntarily submit to a Urinalysis Drug Screen, or any other such familiar examination if such an examination is requested or required in the furtherance of this application. I agree to submit to a periodic and scheduled Urinalysis Drug Screen, or other such similar examination if such examinations are required. I agree to submit to a Random Alcohol Test, or other such similar examinations as required by FMCR Part 40. I further agree to submit to Drug Screening and Alcohol Testing if I am involved in a job related accident within the time period required. Should I be given employment by you, I hereby grant Fleet, permission to furnish my Urinalysis Drug Test Results and Breath Alcohol Test Results to other motor carriers contracted to Fleet.

I understand, acknowledge, and agree that the acceptance of this application by the company does not create an actual or implied contract of employment, or confer any right Fleet may have in respect to the employment-at-will relationship between the Company and the Applicant.

Should I be given employment by you, either the position applied for or some other position, now or hereafter, I hereby agree that such employment may be terminated by you at any time without advance notice and without liability to me for wages or salary, except such as may have been earned up to the date of termination.

The foregoing application shall be construed to apply to all positions which I may hereafter hold with Fleet, and upon my employment, I agree to promptly familiarize myself with all government and Fleet and motor carrier rules and regulations applying to such positions, and to faithfully abide by them.

It is also agreed and understood that under the Fair Credit Report Act, Public Law 91-508, I have been told that this investigation may include an investigating Consumer Report including information regarding my character, general reputation, personal characteristics, and mode of living.

I agree that any disputes as a result of Worker Compensation Injury or Illness shall be governed by and according to the benefits provided by the state of Alabama with venue being Franklin County. Misrepresentations as to preexisting physical or mental conditions may void your workers’ compensation benefits.

Fleet is an affirmative action and equal opportunity employer in all phases of its business and personnel matters. Fleet does not discriminate in employment on the basis of race, sex, national origin, age, disability, or any other impermissible criteria. Fleet will not refuse to hire a disabled applicant who is capable of performing the essential requirements of the job with reasonable accommodations. Questions regarding the Fleet’s policy are welcomed and should be addressed to the personnel department.

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

Signed Date

FLEET PERSONNEL CORP.
Employment Agreement

Legal Definitions:

EMPLOYEE

Under section 3401(d) of internal revenue code an “employee” is defined as an individual who Performs services for a employer.

EMPLOYER

Under section 3401(d) of the internal revenue code a “employer” is defined as a person or entity for whom an individual performs or performed any services in whatever nature, as the employer of such person, except that if the person or entity for whom the individual performs services does not control payment of wages for the service. “Employer” means the person having control of payment of wages.

This Agreement made and entered into between the undersigned employee (Employee) and Fleet Personnel Corp., (Fleet) a company organized and existing under the laws of Alabama.

Fleet Personnel, Corp. will be the employer as defined under section 3401(d) of the internal revenue code. Fleet will control and provide payments of wages to the undersigned employee. Employee recognizes Fleet as the Employer of record even though he/she could perform work for Fleet at Fleet customers. Employee agrees to be deemed and employed by Fleet pursuant to the laws of state of Alabama. Any and all disputes concerning any injury or any claim for liability against Fleet., specifically but not limited to Workers Compensation Laws, shall be resolved in accordance with the laws of the State of Alabama, without giving effect to principles of conflicts of law. Misrepresentations as to preexisting physical or mental conditions may void employee’s workers’ compensation benefits. Any lawsuit against Fleet must be filed in the State of Alabama with venue being in Franklin County, Alabama. Employee acknowledges that the choice of law, jurisdiction, and venue are a material portion of employee’s contract with Fleet., and that consideration has been given to the employee as part of the inducement to execute this employment agreement. Employee understands and agrees that this agreement does not confer any right that Fleet may have with respect to the employment at will relationship between the Fleet and employee.

Fleet Personnel Corp. may deduct up to or including five dollars (\$5.00) per court ordered garnishment per paycheck, or the amount allowed by law, whichever is less, for handling and processing such garnishment(s).

Printed Name

Employee’s Signature

Date of Signature



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (*Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.*)

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States (<i>See instructions</i>)	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (<i>See instructions</i>)	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

STOP *Employer Completes Next Page* STOP



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write in This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
 ▶ **Give Form W-4 to your employer.**
 ▶ **Your withholding is subject to review by the IRS.**

2022

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at www.irs.gov/W4App, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . ▶

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____		
	Multiply the number of other dependents by \$500 . . . ▶ \$ _____		
	Add the amounts above and enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ **Employee's signature** (This form is not valid unless you sign it.)

▶ **Date**

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b) – Multiple Jobs Worksheet *(Keep for your records.)*



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3 1 \$ _____

- 2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a 2a \$ _____
 - b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b 2b \$ _____
 - c Add the amounts from lines 2a and 2b and enter the result on line 2c 2c \$ _____

- 3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3 _____

- 4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) 4 \$ _____

Step 4(b) – Deductions Worksheet *(Keep for your records.)*



- 1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income 1 \$ _____

- 2 Enter: $\left\{ \begin{array}{l} \bullet \$25,900 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$19,400 \text{ if you're head of household} \\ \bullet \$12,950 \text{ if you're single or married filing separately} \end{array} \right\}$ 2 \$ _____

- 3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" 3 \$ _____

- 4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information 4 \$ _____

- 5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 5 \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



1811004012

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME 1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route) 2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 - 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

- A. Single: Enter 0 or 1
B. Married Filing Joint, both spouses working: Enter 0 or 1
C. Married Filing Joint, one spouse working: Enter 0 or 1 or 2
D. Married Filing Separate: Enter 0 or 1
E. Head of Household: Enter 0 or 1

4. DEPENDENT ALLOWANCES []

5. ADDITIONAL ALLOWANCES []
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING \$

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES

(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:

Yourself: [] Age 65 or over [] Blind
Spouse: [] Age 65 or over [] Blind Number of boxes checked x 1300 \$

2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

- A. Federal Estimated Itemized Deductions (If Itemizing Deductions) \$
B. Georgia Standard Deduction (enter one): Single/Head of Household \$4,600
Each Spouse \$3,000 \$
C. Subtract Line B from Line A (If zero or less, enter zero) \$
D. Allowable Deductions to Federal Adjusted Gross Income \$
E. Add the Amounts on Lines 1, 2C, and 2D \$
F. Estimate of Taxable Income not Subject to Withholding \$
G. Subtract Line F from Line E (if zero or less, stop here) \$
H. Divide the Amount on Line G by \$3,000. Enter total here and on Line 5 above

(This is the maximum number of additional allowances you can claim. If the remainder is over \$1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) TOTAL ALLOWANCES (Total of Lines 3 - 5)
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) Read the Line 8 instructions on page 2 before completing this section.

- a) I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. Check here
b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as provided on page 2. My state of residence is My spouse's (servicemember) state of residence is The states of residence must be the same to be exempt. Check here

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature Date

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding. If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, 1800 Century Blvd NE, Suite 8200, Atlanta, GA 30345

9. EMPLOYER'S NAME AND ADDRESS: EMPLOYER'S FEIN:

EMPLOYER'S WH#:

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the number of allowances you are claiming in the brackets beside your marital status.

- A. Single – enter 1 if you are claiming yourself
- B. Married Filing Joint, both spouses working – enter 1 if you claim yourself
- C. Married Filing Joint, one spouse working – enter 1 if you claim yourself or 2 if you claim yourself and your spouse
- D. Married Filing Separate – enter 1 if you claim yourself
- E. Head of Household – enter 1 if you claim yourself

Line 4: Enter the number of dependent allowances you are entitled to claim.

Line 5: Complete the worksheet on Form G-4 if you claim additional allowances. Enter the number on Line H here.

Failure to complete and submit the worksheet will result in automatic denial on your claim.

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 3-5.

Line 8:

- a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You cannot claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

EXAMPLES: Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was \$100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was \$0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore you **qualify** to claim exempt.

- b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:
 1. The servicemember is present in Georgia in compliance with military orders;
 2. The spouse is in Georgia solely to be with the servicemember;
 3. The servicemember maintains domicile in another state; and
 4. The domicile of the spouse is the same as the domicile of the servicemember or the spouse of the servicemember has elected to use the same residence for purposes of taxation as the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 the employer should not report any of the wages as Georgia wages.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Worksheet for calculating additional allowances. Enter the information as requested by each line. For Line 2D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

Do not complete Lines 3-7 if claiming exempt.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue for approval. Employers will honor the properly completed form as submitted pending notification from the Withholding Tax Unit. Upon approval, such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

Post Employment
Medical History Form

HAVE YOU EVER HAD		YES	NO	HAVE YOU EVER HAD		YES	NO
1	Convulsions			29	Insomnia, or other sleep disorders		
2	Hand/Wrist/Arm Injury			30	Skin disease or allergy		
3	Malaria or tropical disease			31	Thyroid or goiter trouble		
4	Blood, pus or albumin in urine			32	Eye trouble (except glasses)		
5	Sugar in urine or diabetes, excessive thirst			33	Ear or hearing trouble		
6	Hernia or rupture			34	Reaction to drugs or medications		
7	Cancer or tumors			35	Accidents or injuries		
8	Varicose veins or swelling of feet			36	Kidney or bladder disorders or trouble		
9	Joint pains, arthritis or bursitis			37	Prostate problems		
10	Osteomyelitis			38	Syphilis/gonorrhea (circle)		
11	Broken bones			39	Chest pain or angina		
12	Prolonged tiredness or fatigue			40	High blood pressure		
13	Anemia or blood disease			41	Heart disease or attacks		
14	Asthma or bronchitis			42	Any heart problems		
15	Hay fever or other allergies			43	Rheumatic fever		
16	Frequent colds or sore throats			44	Shortness of breath		
17	Persistent or chronic cough			45	Tuberculosis or lung problems		
18	Cough, spit up or vomit blood			46	Head injury		
19	Stomach, ulcer or intestinal trouble			47	Joint problems		
20	Rectal trouble of hemorrhoids			48	Epilepsy, fits or convulsions		
21	Bloody or black stools			49	Hepatitis, liver trouble or jaundice		

22	Have you ever been treated for back problems?			50	Have you ever been hospitalized?		
23	Have you ever had back surgery, injury or disease?			51	Have you ever had surgery?		
24	Have you ever been treated by a chiropractor?			52	Are you presently taking any medications		
25	Have you ever received psychological counseling?			53	Have you ever been injured on the job?		
26	Do you smoke?			54	Have you ever gotten Work Comp benefits?		
27	Have you ever had any drug or alcohol problem?			55	Do you have a lawsuit pending as a result of illness, accident, or employment?		
28	Have you ever received counseling for drug or alcohol problems?						

If you answered "yes" to any question above, please put number and explain below:

I hereby certify that all this medical history is correct and complete to the best of my knowledge. I willingly submit this information to Fleet and understand that it will become a part of my medical record. Misrepresentation as to preexisting physical or mental conditions may void workers' compensation benefits.

TO WHOM IT MAY CONCERN:

I hereby authorize Fleet to obtain any medical documentation or information concerning my past, present, or future medical condition from any provider of such information. I hereby release all such persons from any liability or damages.

Applicant's Signature

Date

THE BELOW DISCLOSURE AND AUTHORIZATION LANGUAGE IS FOR MANDATORY USE BY ALL ACCOUNT HOLDERS

**IMPORTANT DISCLOSURE
REGARDING BACKGROUND REPORTS FROM THE PSP Online Service**

In connection with your application for employment with Fleet (“Prospective Employer”), Prospective Employer, its employees, agents or contractors may obtain one or more reports regarding your driving, and safety inspection history from the Federal Motor Carrier Safety Administration (FMCSA).

When the application for employment is submitted in person, if the Prospective Employer uses any information it obtains from FMCSA in a decision to not hire you or to make any other adverse employment decision regarding you, the Prospective Employer will provide you with a copy of the report upon which its decision was based and a written summary of your rights under the Fair Credit Reporting Act before taking any final adverse action. If any final adverse action is taken against you based upon your driving history or safety report, the Prospective Employer will notify you that the action has been taken and that the action was based in part or in whole on this report.

When the application for employment is submitted by mail, telephone, computer, or other similar means, if the Prospective Employer uses any information it obtains from FMCSA in a decision to not hire you or to make any other adverse employment decision regarding you, the Prospective Employer must provide you within three business days of taking adverse action oral, written or electronic notification: that adverse action has been taken based in whole or in part on information obtained from FMCSA; the name, address, and the toll free telephone number of FMCSA; that the FMCSA did not make the decision to take the adverse action and is unable to provide you the specific reasons why the adverse action was taken; and that you may, upon providing proper identification, request a free copy of the report and may dispute with the FMCSA the accuracy or completeness of any information or report. If you request a copy of a driver record from the Prospective Employer who procured the report, then, within 3 business days of receiving your request, together with proper identification, the Prospective Employer must send or provide to you a copy of your report and a summary of your rights under the Fair Credit Reporting Act.

Neither the Prospective Employer nor the FMCSA contractor supplying the crash and safety information has the capability to correct any safety data that appears to be incorrect. You may challenge the accuracy of the data by submitting a request to <https://dataqs.fmcsa.dot.gov>. If you challenge crash or inspection information reported by a State, FMCSA cannot change or correct this data. Your request will be forwarded by the DataQs system to the appropriate State for adjudication.

Any crash or inspection in which you were involved will display on your PSP report. Since the PSP report does not report, or assign, or imply fault, it will include all Commercial Motor Vehicle (CMV) crashes where you were a driver or co-driver and where those crashes were reported to FMCSA, regardless of fault. Similarly, all inspections, with or without violations, appear on the PSP report. State citations associated with Federal Motor Carrier Safety Regulations (FMCSR) violations that have been adjudicated by a court of law will also appear, and remain, on a PSP report.

The Prospective Employer cannot obtain background reports from FMCSA without your authorization.

AUTHORIZATION

If you agree that the Prospective Employer may obtain such background reports, please read the following and sign below:

I authorize Fleet (“Prospective Employer”) to access the FMCSA Pre-Employment Screening Program (PSP) system to seek information regarding my commercial driving safety record and information regarding my safety inspection history. I understand that I am authorizing the release of safety performance information including crash data from the previous five (5) years and inspection history from the previous three (3) years. I understand and acknowledge that this release of information may assist the Prospective Employer to make a determination regarding my suitability as an employee.

I further understand that neither the Prospective Employer nor the FMCSA contractor supplying the crash and safety information has the capability to correct any safety data that appears to be incorrect. I understand I may challenge the accuracy of the data by submitting a request to <https://dataqs.fmcsa.dot.gov>. If I challenge crash or inspection information reported by a State, FMCSA cannot change or correct this data. I understand my request will be forwarded by the DataQs system to the appropriate State for adjudication.

I understand that any crash or inspection in which I was involved will display on my PSP report. Since the PSP report does not report, or assign, or imply fault, I acknowledge it will include all CMV crashes where I was a driver or co-driver and where those crashes were reported to FMCSA, regardless of fault. Similarly, I understand all inspections, with or without violations, will appear

on my PSP report, and State citations associated with FMCSR violations that have been adjudicated by a court of law will also appear, and remain, on my PSP report. I have read the above Disclosure Regarding Background Reports provided to me by Prospective Employer and I understand that if I sign this Disclosure and Authorization, Prospective Employer may obtain a report of my crash and inspection history. I hereby authorize Prospective Employer and its employees, authorized agents, and/or affiliates to obtain the information authorized above.

Date: _____

Signature

Name (Please Print)

NOTICE: This form is made available to monthly account holders by NIC on behalf of the U.S. Department of Transportation, Federal Motor Carrier Safety Administration (FMCSA). Account holders are required by federal law to obtain an Applicant's written or electronic consent prior to accessing the Applicant's PSP report. Further, account holders are required by FMCSA to use the language contained in this Disclosure and Authorization form to obtain an Applicant's consent. The language must be used in whole, exactly as provided. Further, the language on this form must exist as one stand-alone document. The language may NOT be included with other consent forms or any other language.

LAST UPDATED 12/22/2015

Authorization

Authorization: By signing below, you authorize: (a) backgroundchecks.com ("BGC") to request information about you from any public or private information source; (b) anyone to provide information about you to BGC; (c) BGC to provide us (Fleet) one or more reports based on that information; and (d) us to share those reports with others for legitimate business purposes related to your employment. BGC may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an applicant or employee with us.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

Personal Information: Please print the information requested below to identify yourself for BGC.

Printed name:

First Middle (none) Last

Other names used:

Current and former addresses:

from Mo/Yr current to Mo/Yr Street City, State & Zip

from Mo/Yr to Mo/Yr Street City, State & Zip

from Mo/Yr to Mo/Yr Street City, State & Zip

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

Date of birth

Social security number

Driver's license number & state

Name as it appears on license

Email address

Report Copy: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: .

Signature

Date

Disclosure

We (Fleet) will obtain one or more consumer reports or investigative consumer reports (or both) about you for employment purposes. These purposes may include hiring, contract, assignment, promotion, re-assignment, and termination. The reports will include information about your character, general reputation, personal characteristics, and mode of living.

We will obtain these reports through a consumer reporting agency. Our consumer reporting agency is backgroundchecks.com ("BGC"). BGC's address is P.O. Box 353, Chapin, SC 29036. BGC's telephone number is (866) 265-6602. BGC's website is www.backgroundchecks.com, where you can find information about whether BGC's international privacy practices.

To prepare the reports, BGC may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources.

You may obtain a copy of any report that BGC provides and BGC's files about you (in person, by mail, or by phone) by providing identification to BGC. If you do, BGC will provide you help to understand the files, including trained personnel and an explanation of any codes. Another person may accompany you by providing identification.

If BGC obtains any information by interview, you have the right to obtain a complete and accurate disclosure of the scope and nature of the investigation performed.

Please sign below to acknowledge your receipt of this disclosure.

Signature

Date

Printed Name

General Consent for Limited Queries of FMCSA Drug and Alcohol Clearinghouse

I, _____, hereby provide consent to Fleet and my assigned Motor Carrier and its TPA/Consortium to conduct a Limited Query of FMCSA Commercial Driver's License Drug and Alcohol Clearinghouse to determine whether drug or alcohol violation information about me exists in the Clearinghouse.

This consent is for multiple limited queries thru the duration of my employment. These number of Limited Queries are unlimited during the duration of my employment.

I understand that if the Limited Query conducted indicates that drug or alcohol violation information about me exists in the Clearinghouse, FMCSA will not disclose that information to the Motor Carrier/TPA/Consortium without first obtaining additional specific consent. I understand that I must set myself up on the website of the FMCSA at <https://clearinghouse.fmcsa.dot.gov/>

I also understand that I will need to keep my email and password in a safe place. Should a Full Query be necessary, I have 24 hours from the notification to login and give an electronic consent for the Full Query.

I further understand that if I refuse to provide consent for the Motor Carrier and Fleet to conduct a Limited query of the Clearinghouse, the Motor Carrier must prohibit me from performing safety-sensitive functions, including driving a commercial motor vehicle, as required by FMCSA's drug and alcohol program regulations.

Employee Signature

Date

AUTHORIZATION FOR INVESTIGATION AND INQUIRIES

I authorize FLEET to make such investigations and inquiries of my personal, employment, background, financial or medical history and other related matters as may be necessary in arriving at an employment decision. (Generally, inquiries regarding medical history will be made only if and after a conditional offer, if employment has been extended.) This authorization includes but is not limited to:

Criminal Background Checks

Lawsuit Checks

PSP

MVR

I hereby release employers, schools, health care providers and other persons from all liability in responding to inquiries and releasing information in connection with this application.

These investigations and inquiries are in accordance with the provisions of Section 604, 605(b)(2)a) and 607 of the Fair Credit Reporting Act, Public Law 91-508 and 92-508, as amended by the Consumer Credit Reporting Act of 1996 (Title II, Subtitle D, Chapter I, of Public Law 104-208). These reports are required by Sections 382.413, 391.23 and 391.25 of the Federal Motor Carrier Safety Regulations.

In the event of employment, I understand that false or misleading information given in my application or interview may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the COMPANY.

I understand that information I provide regarding current and/or previous employers may be used and those employers will be contacted, for the purpose of investigating my safety performance history as required by 49 CFR 391.23(d) and (e). I understand that I have the right to:

*Review information provided by previous employers.

*have errors in the information corrected by previous employers, and for those previous employers to re-send the corrected information to the prospective employer; and

Have a rebuttal statement attached to the alleged erroneous information, if the previous employer(s) and I cannot agree on the accuracy of the information.

Applicant's Signature

Date

Print Name

Social Security Number

License Number

State

Date of Birth

**NOTICE TO DRIVERS
&
CERTIFICATE OF COMPLIANCE**

(Note: Original to be retained by carrier, copy for driver)

I. NOTICE TO DRIVERS

The commercial Motor Vehicle Safety Act of 1986 provides for stronger controls over drivers of commercial vehicles. The new law applies to all drivers operating vehicles and combinations with a Gross Vehicle Weight Rating over 26,000 pounds, and to any vehicle, regardless of weight, transporting hazardous materials in a quantity requiring placarding.

The following provisions of this legislation became effective July 1, 1987:

1. No driver may possess more than one license, and no motor carrier may use a driver having more than one license.
2. A driver convicted of a traffic violation (other than parking) in any vehicle must notify the motor carrier AND the state which issued the license to that driver of the conviction within 30 days.
3. Any person applying for a job as a commercial vehicle driver must inform the prospective employer of all previous employment as the driver of a commercial vehicle for the past 10 years, in addition to any other required information about the applicant's employment history.
4. The Federal Motor Carrier Safety Regulations require that a driver who loses any privilege to operate a commercial vehicle, or who is disqualified from operating a commercial vehicle, must advise the motor carrier the next business day after receiving notification.

PENALTIES - Any violation of the above is punishable by a fine not to exceed \$2,500. Willful violation of (1) or (3) above, or failure to notify the motor carrier within 30 days of the loss of any privilege to operate a commercial vehicle can result in criminal penalties not to exceed \$5,000 and /or 90 days in jail.

II. CERTIFICATION BY DRIVER

I hereby certify that I have read the above and understand the driver provisions of the Commercial Motor Vehicle Safety Act of 1986, which became effective on July 1, 1987.

Driver's Name (print) _____ Soc. Sec. _____

Driver's Address _____

License: State _____ Type/Class _____ ID No. _____

Driver's Signature: _____

**MOTOR VEHICLE DRIVER'S
Certification of Violations/Annual Review of Driving Record**

MOTOR CARRIER INSTRUCTIONS: Each motor carrier shall at least once every 12 months, require each driver it employs to prepare and furnish it with a list of all motor vehicle traffic laws and ordinances (other than violations involving only parking) of which the driver has been convicted, or on account of which he/she has forfeited bond or collateral during the preceding 12 months (Section 391.27). Drivers who have provided information required by Section 383.31 need not repeat that information on the form.

DRIVER REQUIREMENTS: Each driver shall furnish the list as required by the motor carrier above. If the driver has not been convicted of, or forfeited bond or collateral on account of any violation which must be listed, he/she shall so certify (Section 391.27).

COMPLETED BY DRIVER – CERTIFICATION OF VIOLATIONS

NAME OF DRIVER: (PRINT)	SOCIAL SECURITY NUMBER	DATE OF EMPLOYMENT
HOME TERMINAL: (CITY AND STATE)	DRIVER'S LICENSE NUMBER	STATE
		EXPIRATION DATE

I certify that the following is a true and complete list of traffic violations required to be listed (other than those I have provided under Part 383) for which I have been convicted or forfeited bond or collateral during the past 12 months.
(If you have had no violations, check the following box - None.)

DATE	OFFENSE	LOCATION	TYPE OF VEHICLE OPERATED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If no violations are listed above, I certify that I have not been convicted or forfeited bond or collateral on account of any violation (other than those I have provided under Part 383) required to be listed during the past 12 months.

Date of Certification: _____ **Driver's Signature:** _____

COMPLETED BY MOTOR CARRIER – ANNUAL REVIEW OF DRIVING RECORD

MOTOR CARRIER INSTRUCTIONS: Review the Certification of Violations listed above and other information described in Section 391.25 of the Federal Motor Carrier Safety Regulations. Complete the information requested below.

I have hereby reviewed the driving record of the above named driver in accordance with Section 391.25 and find that he/she (check one):

- Meets minimum requirements for safe driving Is disqualified to drive a motor vehicle pursuant to Section 391.15
- Does not adequately meet satisfactory safe driving performance

Action take with driver: _____

Reviewed by: _____
Signature Date

_____ Title
Printed Name

Motor Carrier Name _____ Motor Carrier Address _____

DRIVER DATA SHEET

For Casuals, New Hires & Temporary Employees

Name (Print): _____

Social Security Number: _____

Motor Vehicle Operator's License Number: _____

Type of License: _____ Issuing State: _____

Instructions: Motor carriers when using a driver for the first time or intermittently shall obtain from the driver a signed statement giving the total time on duty during the immediately preceding 7 days and time at which such driver was last relieved from duty prior to beginning work for such carrier. Rule 395.8(j)(2) Federal Motor Carrier Safety Regulations.

Day	1	2	3	4	5	6	7	TOTAL
Date								
Hours Worked								

I certify that the information given above is correct to the best of my knowledge and belief, and that I was last relieved from work at _____ on _____ / _____ / _____.

Time Month Day Year

(Signature) _____

Witness: _____ Date: _____
 (Company Representative)

EMPLOYMENT CHECKLIST FOR INTERMITTENT, CASUAL OR OCCASIONAL DRIVER

The qualification file for an intermittent, casual, or occasional driver employed under the rules in Sec. 391.63 must include the following forms as per Section 391.51(d) Federal Motor Carrier Safety Regulations.

1. Medical Examiner's Certificate – The medical examiner's certificate of his Physical qualification to drive a motor vehicle or a legible photographic copy of the certificate pursuant to Sec. 391.43. _____
2. Certificate of Driver's Road Test – The certificate of driver's road test issued to the driver pursuant to Sec. 391.31(e), or a cop of the license or certificate which motor carrier accepted as equivalent to the driver's road test pursuant to Sec.391.31. _____
3. Certificate of Written Examination, Questions and Answers – The questions asked, the answers the driver gave, and the certificate of written examination issued to him pursuant to Sec.391.35(G), or a copy of a certificate which the motor carrier accepted as equivalent to a written examination pursuant to Sec.391.37. _____

Please note that the testing regulations must also be complied with for an intermittent, casual, or occasional driver.

REQUEST FOR CHECK OF DRIVING RECORD

I hereby authorize you to release the following information to FLEET for purposes of investigation as required by Section 391.23 of the Federal Motor Carrier Safety Regulations. You are released from any and all liability which may result from furnishing such information.

(Applicant's Signature) (Date)

1. In accordance with the provisions of Section 604 and Section 607 of the Fair Credit Reporting Act, Public Law No. 91-508, I hereby certify that the information requested below will be used for a "permissible purpose" as defined in the Act, and that the information received will be used for no other purpose.
2. I further certify that if the applicant named below is denied employment based upon the information received, I will identify the source of the report in accordance with Section 615(a) of the Fair Credit Reporting Act.

(Signature of Requestor) (Date)

TO: _____

GENTLEMEN:

The following named person has made application with our company for the position of _____. As in accordance with Section 391.23. Federal Department of Transportation Regulations, please furnish the undersigned with the applicant's driving record for the past three years.

NAME OF APPLICANT: _____

ADDRESS: _____
(Number and Street) (City) (State) (Zip)

FORMER ADDRESS: _____
(Number and Street) (City) (State) (Zip)

BIRTH DATE: _____ SOC SEC#: _____ LIC #: _____

REQUESTED BY

(Name of Company) (Typed Name)

(Address) (Title)

(City) (State) (Signature)

Request/Consent For Information From Previous Employer on Alcohol & Controlled Substances Testing

SECTION 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name) _____
First, M.I., Last _____ Social Security Number _____

Hereby authorize that:

Previous Employer: _____ Telephone: _____
Street: _____ Fax No.: _____
City, State, Zip: _____

may release and forward information requested by section 2 (below) of this document concerning my previous employment information and my Alcohol and Controlled Substance Testing Records to:

Prospective Employer/Motor Carrier: **Fleet** Telephone: **(800) 344-3748 ext. 540**
Attention: **DOT Specialist** Fax No.: **(256) 740-5560**
Street: **705 Cross Street** Email: **driverdot@driverhq.us**
City, State, Zip: **Russellville, AL 35653**

Applicant's Signature _____ **Date** _____

This is in compliance with Sections 382.405(f) and (h), which state:
(f) Records shall be made available to a subsequent employer upon receipt of a written request from a driver. Disclosure by that subsequent employer is permitted only as expressly authorized by the terms of the driver's request.
(g) An employer shall release information regarding driver's records as directed by the specific, written consent of the driver's authorizing release of the information to an identified person. Release of such information by the person receiving the information is permitted only in accordance with the terms of the employee's consent.
Sections 382.413(a)(b)(c)(e)(f) further state:
(a) An employer may obtain, pursuant to a driver's written consent, any of the information concerning the driver which is maintained under this part by the driver's previous employer.
(b) An employer shall obtain, pursuant to a driver's consent, information on the driver's alcohol tests with a concentration result of 0.04 or greater, positive controlled substance test results, and refusals to be tested, within the preceding two years, which are maintained by the driver's previous employers under Section 382.401(b)(1)(i) through (iii).
(c) The information in paragraph (b) of this section must be obtained and reviewed by the employer no later than 14 calendar days after the first time a driver performs safety-sensitive functions for an employer.
(e) The prospective employer must provide to each of the driver's employers within the two proceeding years the driver's specific written authorization for release of the information in paragraph (b).
(f) The release of any information under this part may take the form of personal interviews, telephone interviews, letters or any other method of obtaining information that ensures confidentiality. Each employer must maintain written, confidential records with respect to each past employer contacted.

SECTION 2: TO BE COMPLETED BY PREVIOUS EMPLOYER

- 1. Dates of employment: From _____ To _____
- 2. Type of Equipment Driven: _____ Area of Operation: _____
- 3. Dates of Any Accidents: _____
- 4. Reason for Leaving: _____ Eligible for Rehire?: _____

COMPLETE THIS SECTION AS IT PERTAINS TO PART 382. SEE SEC.382.413(b), ABOVE

During the last (2) two years has this person ever:

- 1. tested positive for a controlled substance ? _____ YES _____ NO
- 2. had an alcohol test with a Breath Alcohol Concentration of 0.04 or greater? _____ YES _____ NO
- 3. refused a required test for drugs or alcohol? _____ YES _____ NO

If YES to any of the above questions, please give the SAP's (Substance Abuse Professional) information:

Name: _____
Street: _____ City, State, Zip: _____

Section 2 Completed by (Signature) _____ **Date:** _____

SECTION 3: TO BE COMPLETED BY PROSPECTIVE EMPLOYER

This form was (check one) _____ Faxed to previous employer. _____ Mailed Date: _____

Return Information Received From: _____

Recorded by: _____ Method: _____ Fax _____ Mail _____ Phone
Date: _____ _____ Personal Interview

Request/Consent For Information From Previous Employer on Alcohol & Controlled Substances Testing

SECTION 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name) _____
First, M.I., Last _____ Social Security Number _____

Hereby authorize that:

Previous Employer: _____ Telephone: _____
Street: _____ Fax No.: _____
City, State, Zip: _____

may release and forward information requested by section 2 (below) of this document concerning my previous employment information and my Alcohol and Controlled Substance Testing Records to:

Prospective Employer/Motor Carrier: **Fleet** Telephone: **(800) 344-3748 ext. 540**
Attention: **DOT Specialist** Fax No.: **(256) 740-5560**
Street: **705 Cross Street** Email: **driverdot@driverhq.us**
City, State, Zip: **Russellville, AL 35653**

Applicant's Signature _____ **Date** _____

This is in compliance with Sections 382.405(f) and (h), which state:
(f) Records shall be made available to a subsequent employer upon receipt of a written request from a driver. Disclosure by that subsequent employer is permitted only as expressly authorized by the terms of the driver's request.
(g) An employer shall release information regarding driver's records as directed by the specific, written consent of the driver's authorizing release of the information to an identified person. Release of such information by the person receiving the information is permitted only in accordance with the terms of the employee's consent.
Sections 382.413(a)(b)(c)(e)(f) further state:
(a) An employer may obtain, pursuant to a driver's written consent, any of the information concerning the driver which is maintained under this part by the driver's previous employer.
(b) An employer shall obtain, pursuant to a driver's consent, information on the driver's alcohol tests with a concentration result of 0.04 or greater, positive controlled substance test results, and refusals to be tested, within the preceding two years, which are maintained by the driver's previous employers under Section 382.401(b)(1)(i) through (iii).
(c) The information in paragraph (b) of this section must be obtained and reviewed by the employer no later than 14 calendar days after the first time a driver performs safety-sensitive functions for an employer.
(e) The prospective employer must provide to each of the driver's employers within the two proceeding years the driver's specific written authorization for release of the information in paragraph (b).
(f) The release of any information under this part may take the form of personal interviews, telephone interviews, letters or any other method of obtaining information that ensures confidentiality. Each employer must maintain written, confidential records with respect to each past employer contacted.

SECTION 2: TO BE COMPLETED BY PREVIOUS EMPLOYER

1. Dates of employment: From _____ To _____
2. Type of Equipment Driven: _____ Area of Operation: _____
3. Dates of Any Accidents: _____
4. Reason for Leaving: _____ Eligible for Rehire?: _____

COMPLETE THIS SECTION AS IT PERTAINS TO PART 382. SEE SEC.382.413(b), ABOVE

During the last (2) two years has this person ever:

1. tested positive for a controlled substance ? _____ YES _____ NO
2. had an alcohol test with a Breath Alcohol Concentration of 0.04 or greater? _____ YES _____ NO
3. refused a required test for drugs or alcohol? _____ YES _____ NO

If YES to any of the above questions, please give the SAP's (Substance Abuse Professional) information:

Name: _____
Street: _____ City, State, Zip: _____

Section 2 Completed by (Signature) _____ **Date:** _____

SECTION 3: TO BE COMPLETED BY PROSPECTIVE EMPLOYER

This form was (check one) _____ Faxed to previous employer. _____ Mailed Date: _____

Return Information Received From: _____

Recorded by: _____ Method: _____ Fax _____ Mail _____ Phone
Date: _____ _____ Personal Interview

Request/Consent For Information From Previous Employer on Alcohol & Controlled Substances Testing

SECTION 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name) _____
First, M.I., Last _____ Social Security Number _____

Hereby authorize that:

Previous Employer: _____ Telephone: _____
Street: _____ Fax No.: _____
City, State, Zip: _____

may release and forward information requested by section 2 (below) of this document concerning my previous employment information and my Alcohol and Controlled Substance Testing Records to:

Prospective Employer/Motor Carrier: **Fleet** Telephone: **(800) 344-3748 ext. 540**
Attention: **DOT Specialist** Fax No.: **(256) 740-5560**
Street: **705 Cross Street** Email: **driverdot@driverhq.us**
City, State, Zip: **Russellville, AL 35653**

Applicant's Signature _____ **Date** _____

This is in compliance with Sections 382.405(f) and (h), which state:
(f) Records shall be made available to a subsequent employer upon receipt of a written request from a driver. Disclosure by that subsequent employer is permitted only as expressly authorized by the terms of the driver's request.
(g) An employer shall release information regarding driver's records as directed by the specific, written consent of the driver's authorizing release of the information to an identified person. Release of such information by the person receiving the information is permitted only in accordance with the terms of the employee's consent.
Sections 382.413(a)(b)(c)(e)(f) further state:
(a) An employer may obtain, pursuant to a driver's written consent, any of the information concerning the driver which is maintained under this part by the driver's previous employer.
(b) An employer shall obtain, pursuant to a driver's consent, information on the driver's alcohol tests with a concentration result of 0.04 or greater, positive controlled substance test results, and refusals to be tested, within the preceding two years, which are maintained by the driver's previous employers under Section 382.401(b)(1)(i) through (iii).
(c) The information in paragraph (b) of this section must be obtained and reviewed by the employer no later than 14 calendar days after the first time a driver performs safety-sensitive functions for an employer.
(e) The prospective employer must provide to each of the driver's employers within the two proceeding years the driver's specific written authorization for release of the information in paragraph (b).
(f) The release of any information under this part may take the form of personal interviews, telephone interviews, letters or any other method of obtaining information that ensures confidentiality. Each employer must maintain written, confidential records with respect to each past employer contacted.

SECTION 2: TO BE COMPLETED BY PREVIOUS EMPLOYER

1. Dates of employment: From _____ To _____
2. Type of Equipment Driven: _____ Area of Operation: _____
3. Dates of Any Accidents: _____
4. Reason for Leaving: _____ Eligible for Rehire?: _____

COMPLETE THIS SECTION AS IT PERTAINS TO PART 382. SEE SEC.382.413(b), ABOVE

During the last (2) two years has this person ever:

1. tested positive for a controlled substance ? _____ YES _____ NO
2. had an alcohol test with a Breath Alcohol Concentration of 0.04 or greater? _____ YES _____ NO
3. refused a required test for drugs or alcohol? _____ YES _____ NO

If YES to any of the above questions, please give the SAP's (Substance Abuse Professional) information:

Name: _____
Street: _____ City, State, Zip: _____

Section 2 Completed by (Signature) _____ **Date:** _____

SECTION 3: TO BE COMPLETED BY PROSPECTIVE EMPLOYER

This form was (check one) _____ Faxed to previous employer. _____ Mailed Date: _____

Return Information Received From: _____

Recorded by: _____ Method: _____ Fax _____ Mail _____ Phone
Date: _____ _____ Personal Interview

CERTIFICATION OF TRAINING

I, _____, hereby acknowledge that I have received a sixty (60) minute training program covering Drug and Alcohol Awareness Training, in accordance with the Federal Motor Carrier Safety Regulations, 49 CFR, Part 391, Subpart H.

I acknowledge access to the Driver Handbook from Fleet and the motor carrier which I have read and fully understand.

Signed

Date

Alcohol And Drug Employee's Certified Receipt

Employee's Name

This is to certify that Fleet has provided educational material required by section 382.601 and my carrier's policies and procedures with respect to meeting the Part 382 requirements. The materials include detailed discussion of the following checked () items:

- _____ 1. The designated person to answer questions about the materials.
- _____ 2. The categories of drivers subject to Part 382.
- _____ 3. Sufficient information about the safety-sensitive functions and periods of the workday that compliance is required.
- _____ 4. Specific information concerning prohibited driver conduct.
- _____ 5. Circumstances under which a driver will be tested.
- _____ 6. Test procedures, driver protection and integrity of the testing processes, and safeguarding the validity of the test.
- _____ 7. The requirement that tests are administered in accordance with Part 382.
- _____ 8. An explanation of what will be considered a refusal to submit to a test and the consequences.
- _____ 9. The consequences for Part 382 Subpart B violations including removal from safety-sensitive functions and Part 40, subpart O procedures.
- _____ 10. The consequences for drivers found to have an alcohol concentration of 0.02 or greater but less than 0.04.
- _____ 11. Information on the affects of alcohol and controlled substances use on:
 - an individual's health
 - work
 - personal life
 - signs and symptoms of a problem
 - available methods of intervening when a problem is suspected
- _____ 12. Optional information:

Employee's Signature

Date

Authorized Representative

Date

**WRITTEN AUTHORIZATION FOR URINALYSIS TEST
RESULTS TO BE GIVEN TO OTHER PARTIES**

I hereby authorize and agree to allow Fleet to provide the results of any and all urinalysis test results pertaining to either pre-employment and or post-employment test taken by me.

I understand that Fleet, as a provider of regulated drivers, must furnish its customers with documentation as to my qualifications as required by law.

I also understand that this authorization is restricted to the following:

- A. Customers of Fleet where I have been assigned as a regulated driver under the definitions and requirements of the Federal Department of Transportation, Federal Highway Administration's Motor Carrier Safety Regulations.
- B. Affiliated Motor Carriers of Fleet.

Applicant Name

Applicant Signature

Date

Witnessed by:

Motor Carrier Representative Signature

Date

PREVIOUS PRE-EMPLOYMENT EMPLOYEE ALCOHOL AND DRUG TEST STATEMENT

Sec. 40.25(j) As the employer/carrier, you must also ask the employee whether he or she has tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer/carrier to which the employee applied for, but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol testing rules during the past two years. If the employee admits that he or she had a positive test or a refusal to test, you must not use the employee to perform safety-sensitive functions for you, until and unless the employee documents successful completion of the return-to-duty process. (see Sec. 40.25(b)(5) and (e))

Prospective Employee Name: _____
(Print)

The prospective employee is required by Sec. 40.25(j) to respond to the following questions:

1. Have you tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which you applied for, but did not obtain, safety-sensitive transportation work covered by the DOT agency drug and alcohol testing rules during the past two years?

Check one: Yes No

2. If you answered yes, can you provide/obtain proof that you've successfully completed the DOT return-to-duty requirements?

Check one: Yes No

I certify that the information provided on this document is true and correct.

Prospective Employee Signature: _____ Date: _____

Witnessed by (Signature): _____ Date: _____

DFWP Pre-Employment Consent Form

Pre-Employment Tests Only

Applicants, please read and sign below

Pre-Employment/Pre-Placement Consent

I understand, as required by the company policy, all prospective employees must submit to a drug and/or alcohol test. A urine specimen will be collected at a site selected by the company and tested for drugs at a DHHS/SAMSHA-certified laboratory. The laboratory results of the drug test will be reviewed, reported, and maintained by the Medical Review Officer (MRO) selected by the company. If the drug test result is negative, the MRO will report the test result to the company. I will be given an opportunity to discuss a positive laboratory test result with the MRO before the drug test is reported to the company as a verified positive. I consent to the release of test results to the company's third-party administrator (currently SecurePoint Health Services), within the company on a need-to-know basis and to additional parties in accordance with my written authorization or as otherwise required by applicable federal or state law.

I also understand that, if hired, I will be required to submit to additional drug and/or alcohol tests as outlined in the company policy and supportive material.

I hereby agree to voluntarily submit to a drug and/or alcohol test and further understand that if said test(s) is verified/confirmed as a positive drug and/or alcohol test and/or if it is determined that there has been any interference with the collection or testing process (including adulteration and/or switching specimens), I will be considered unqualified for employment by the company.

Employment is conditioned on a negative test result and hiring will not become final unless the individual passes the required drug test.

If you have any questions, please discuss them with the company before signing.

Applicant Signature: _____ **Date:** _____

Required if applicant is less than 18 years of age:

I am the parent/guardian of _____. I hereby consent to his/her participation in a pre-employment drug and/or alcohol test as detailed above. I understand that test results will be only be disclosed to the applicant.

Parent/Guardian Signature: _____ **Date:** _____

NOTE: This certificate should be retained in a secured file.

DFWP Acknowledgement of Receipt of Policy and Consent to Testing

I certify that I have received and understand Fleet's Drug-Free Workplace Program Policy.

I agree to comply with the company's policy on drugs and/or alcohol and understand failure to comply is grounds for disciplinary action, up to and including termination.

I consent to submit to drug and/or alcohol testing as outlined in the company's policy.

I consent to provide specimens at the assigned collection site(s) and further consent to have urine specimens tested for drugs at a U.S. Department of Health & Human Services/Substance Abuse & Mental Health Services Administration (DHHS/SAMHSA)-certified laboratory.

I consent to the release of the drug and/or alcohol test results in accordance with the company policy to the selected Medical Review Officer (MRO), to the company's third-party administrator to and within the company on a need-to-know basis, and to additional parties in accordance with my written authorization or as otherwise required by applicable federal or state law.

I will be given an opportunity to discuss a positive drug test result with the MRO before the result is reported to the company as a verified positive.

In the event of a post-accident test, the drug and/or alcohol test result(s) may also be provided to the workers' compensation insurance carrier.

Employee Name: _____ Date: _____

Employee Social Security Number: _____

Employee Signature: _____

I am the parent/guardian of _____. I hereby consent to his/her participation in a pre-employment drug and/or alcohol test as detailed above. I understand that test results will be only be disclosed to the applicant.

Parent/Guardian Signature: _____ Date: _____

NOTE: This certificate should be retained in a secured file.

DFWP Post-Accident Checklist

Drug Program Coordinator: Teresa Masterson (256) 332-9576 ext. 547
Patrice Scott (256) 332-9576 ext. 540

Procedures

Step 1: Contact and follow the instructions of the supervisor or law enforcement officer at the scene of an accident. Employees may not leave the scene of an accident until deemed appropriate. **NOTE: The employee is not prohibited from leaving the scene of an accident for the period of time necessary to obtain assistance in responding to the accident or to obtain necessary emergency medical care.**

Step 2: At the first available opportunity, contact the Drug Program Coordinator (DPC) at the telephone number listed above. The DPC will assist you with the necessary steps to ensure policy compliance.

Step 3: Each employee must immediately proceed to the nearest collection site for a drug and alcohol test. Employees are obligated to follow instructions and ensure that the tests are conducted. An employee who is subject to post-accident testing must remain available or it may be assumed that he/she refused to submit to testing. The employee who is subject to post-accident testing must refrain from consuming alcohol for eight (8) hours following the accident, or until he/she submits to an alcohol test, whichever occurs first.

Alcohol Test: The DOT-regulated employee must submit to an alcohol test within two (2) hours of an accident. The employer must document reasons for time delay if the alcohol test is not performed within the two (2) hours. If the employee has not submitted to an alcohol test within eight (8) hours, attempts must cease and a record documenting the reason(s) testing was not possible must be prepared and maintained.

Drug Test: The DOT-regulated employee must submit to a drug test within thirty-two (32) hours of an accident. If the employee has not submitted to a drug test within thirty-two (32) hours, attempts must cease and a record documenting the reason(s) testing was not possible must be prepared and maintained.

Type of Accident	Was a Citation Issued to CMV Driver?	Must a Test be Performed by Employer
Human fatality	Yes	Yes
	No	Yes
Bodily injury with immediate medical Treatment away from the scene	Yes	Yes
	No	No
Disabling damage to any motor Vehicle requiring tow away	Yes	Yes
	No	No

If a collection site needs to be located after hours, please call Lexis Nexis at 1-608-791-0010. Please leave a message and a Representative will contact you as soon as possible.

Note: A checklist must be given to each DOT-regulated employee prior to performing a safety-sensitive function.