

Driver Application for Employment Armour Tight Gunite, LLC

WE CONSIDER ALL APPLICANTS FOR POSITIONS WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, AGE, MARITAL OR VETERAN STATUS, THE PRESENCE OF A NON-JOB RELATED MEDICAL CONDITION OR HANDICAP, OR ANY OTHER LEGALLY PROTECTED STATUS.

Position(s) Applying for _____ Date _____

Name (Last) _____ (First) _____ (MI) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Mobile _____

Social Security No. _____ DOB _____

Driver's License No. _____ MVR Result _____

•Have you ever applied to our company before? Yes No
If yes, when? _____

•Have you ever been employed by us? Yes No
If yes, when? _____

•If you are under 18 years of age, can you provide the required proof of your eligibility to work? Yes No

•Are you currently employed? Yes No

•May we contact your present employer? Yes No

•On what date will you be able to work? _____

•Are you available to work: Full Time Part Time Shift Work Seasonal

• Are you currently on "lay-off" status and subject to recall? Yes No

•Have you been convicted of a felony in the last seven years? (Conviction will not necessarily disqualify an applicant from employment.) Yes No

•If yes, please explain. _____

• Are you a U.S. citizen? Yes No

•If no, do you have any documentation to prove that you are legally eligible to work in the United States? (Proof of citizenship or immigration status will be required upon employment.)

Yes No

•List any friends or relatives who work here. _____

EDUCATION

	Name and Location of School	Years Attended	Date Graduated	Degree or Diploma Earned
High School				
College				
Graduate				
Other				

WORK EXPERIENCE

Employer		Starting Position		Starting Salary	
Street Address		Final Position		Final Salary	
City, State		Job Duties			
Phone Number		Supervisor/ Title			
Dates of Employment	Start: Month	Year	End:Month	Year	
Reason For Leaving					

Employer		Starting Position		Starting Salary	
Street Address		Final Position		Final Salary	
City, State		Job Duties			
Phone Number		Supervisor/ Title			
Dates of Employment	Start: Month	Year	End:Month	Year	
Reason For Leaving					

Employer		Starting Position		Starting Salary	
Street Address		Final Position		Final Salary	
City, State		Job Duties			
Phone Number		Supervisor/ Title			
Dates of Employment	Start: Month	Year	End:Month	Year	
Reason For Leaving					

• Describe any specialized training, apprenticeship, or skill: _____

• Please list any additional job skills that you believe would be relevant to the position for which you are applying. _____

APPLICANT'S STATEMENT

I certify that the information I have provided herein is true and complete to the best of my knowledge. If I become employed by this organization, I agree that any false statement, misrepresentation, or omission may result in my immediate termination.

I hereby authorize Armour Tight Gunite, LLC and/or any of their authorized agents to gather information regarding the following: All records including criminal, credit, driving, and/or education, written or verbal information from previous employers, and any other pertinent information relating to the function of the job for which I am applying.

I understand that all inquiries on this form are used for identification purposes only in order to conduct a background check, and are asked for legitimate nondiscriminatory reasons. Responses to sex, age, and race inquiries are voluntary, and choosing not to respond will preclude hire or promotion. I hereby release former employers, other references, and Armour Tight Gunite, LLC and any of its authorized agents from liability and understand there is no invasion of privacy.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law that my employment is at will. This means I do not have a contract of employment for any particular duration or that limits the grounds for termination in any way. I am free to resign at any time. Similarly, Armour Tight Gunite, LLC is free to terminate my employment at any time for any or no reason. It is further understood that my "at will" employment may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

I understand that I am required to abide by all rules and regulations of the employer.

Name of Applicant _____ Date _____

Signature of Applicant _____

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

Form W-4 (2007)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax

for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners/Multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent. **A** _____

B Enter "1" if:
 You are single and have only one job; or
 You are married, have only one job, and your spouse does not work; or
 Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less. **B** _____

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) **E** _____

F Enter "1" if you have at least \$1,500 of child or dependent care expenses for which you plan to claim a credit **F** _____

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub 972, Child Tax Credit, for more information. **G** _____

- If your total income will be less than \$57,000 (\$85,000 if married), enter "2" for each eligible child.
- If your total income will be between \$57,000 and \$84,000 (\$85,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have 4 or more eligible children.

H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) **H** _____

For accuracy, complete all worksheets that apply.
 If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
 If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married) see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
 If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4	Employee's Withholding Allowance Certificate	OMB No. 1545-0074
Department of the Treasury Internal Revenue Service		2007
Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		
1 Type or print your first name and middle initial.	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		
4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2007, and I certify that I meet both of the following conditions for exemption. <input type="checkbox"/> Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and <input type="checkbox"/> This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here 7 _____		
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.)		Date
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE.** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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):

- A citizen or national of the United States
- A Lawful Permanent Resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #)

Employee's Signature	Date (month/day/year)
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Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. **Examine one document from List A OR examine one document from List B and one from List C** as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	
		Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.	
Document Title: _____	Document #: _____
Expiration Date (if any): _____	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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	Date (month/day/year)
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Health Questionnaire

This questionnaire is not being used as the basis for deciding whether to employ you. It is solely for the purpose of providing information to the Florida Special Disability Trust Fund in appropriate cases.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip _____ Code: _____

Social _____ Security _____ Number: _____
Sex: _____

Date _____ of _____ Birth: _____
Weight: _____ Height: _____

Do you have or have you ever had any of the following? You must answer all questions. Any yes answer must be fully explained below.

	YES	NO		YES	NO
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac (heart) Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Marie Strum Pell Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Virus	<input type="checkbox"/>	<input type="checkbox"/>
Any Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Osteomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Joints	<input type="checkbox"/>	<input type="checkbox"/>
Any Amputation	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Thrompophlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Herniated Intervertebral Disc	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Circulation Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Back Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric or Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Skin Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Treatment or Evaluation	<input type="checkbox"/>	<input type="checkbox"/>

Health Questionnaire – Continued Page 2

Have you ever received treatment for a back, neck or knee condition, or a head injury? _____

Do you now or have you ever suffered from aches or pains of the back? _____

Have you ever had any surgery?

Do you now or have you ever had any physical disabilities, impairments, or handicaps?

Have you ever had a workers' compensation injury?

Have you ever received compensation or medical benefits under worker's compensation?

Are there any questions you do not understand? If yes, which question(s)?

Explain in detail any **YES** answers. _____

I understand and agree that if I am injured on the job, regardless of how minor, I am to report the injury immediately to my supervisor.

I further understand and agree that my employer's workers' compensation carrier will determine the medical facility and/or doctors I am to use.

I certify the above answers to be true and correct. I understand that any false or misleading answers to these questions will be sufficient reason for denial of benefits under the Florida Workers' Compensation Act, and will be the basis for termination.

Date: _____ **Applicant's Signature:**

DRIVER STATEMENT OF ON-DUTY HOURS
(For Newly Hired Drivers)

INSTRUCTIONS: When employed by a motor carrier, a driver must report to the carrier all on-duty time including time working for other employers. The definition of on-duty time found in Section 395.2 paragraphs (8) and (9) of the Federal Motor Carrier Safety Regulations includes time performing any other work in the capacity of, or in the employ or service of, a common, contract or private motor carrier, also performing any compensated work for any non-motor carrier entity.

Are you currently working for another employer?

YES _____ NO _____

At this time do you intend to work for another employer while still employed by this company?

YES _____ NO _____

I hereby certify that the information given above is true and I understand that once I become employed with this company, if I begin working for any additional employer(s) for compensation that I must inform this company immediately of such employment activity.

Drivers signature _____

Date _____

Witness _____

Date _____

Armour Tight Gunite, LLC

3904 15th Street East
Bradenton, FL 34208
(941) 745-1039
Fax (941) 745-2192

FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

**In accordance with the provisions of Section 604(b)(2)(A): 606 and 615
Of the Fair Credit Reporting Act, effective September 30, 1997, you are
being informed that reports verifying your previous employment,
previous drug and alcohol test results, and your driving record
may be obtained on you for employment purposes.**

**NOTE: In accordance with DOT regulations for appropriate drivers these reports
Are required by Sections 382.413, 391.23, and 391.25 of the
Federal Motor Carriers Safety Regulations.**

**I also understand that my employer will periodically review my Motor Vehicle Record to determine
continued eligibility to drive a company vehicle.**

This authorization is valid as long as I am an employee and may only be rescinded in writing.

Candidate and/or Employee Acknowledgment

<hr/>		<hr/>	
Print Full Name as it appears on Driver's License		Date	
<hr/>		<hr/>	
Signature		Social Security Number	
<hr/>		<hr/>	
Birth Date	Driver's License Number	State	Expiration

Motor Vehicle Driver's

**CERTIFICATION OF COMPLIANCE
WITH DRIVER LICENSE REQUIREMENTS**

MOTOR CARRIER INSTRUCTIONS: The requirements in Part 383 apply to every driver who operates in intrastate, interstate, or foreign commerce and operates a vehicle weighing 26,001 pounds or more, can transport more than 15 people, or transports hazardous materials that require placarding.

The requirements in Part 391 apply to every driver who operates in interstate commerce and operates a vehicle weighing 10,001 pounds or more, can transport more than 15 people, or transports hazardous materials that require placarding.

DRIVER REQUIREMENTS: Parts 383 and 391 of the Federal Motor Carrier Safety Regulations contain some requirements that you as a driver must comply with. These requirements are in effect as of July 1, 1987. They are as follows:

1. **POSSESS ONLY ONE LICENSE:** You, as a commercial vehicle driver, may not possess more than one motor vehicle operator's license.

If you have more than one license, keep the license from your state of residence and return the additional licenses to the states that issued them. DESTROYING a license does not close the record in the state that issued it; you must notify the state. If a multiple license has been lost, stolen, or destroyed, close your record by notifying the state of issuance that you no longer want to be licensed by that state.

2. **NOTIFICATION OF LICENSE SUSPENSION, REVOCATION OR CANCELLATION:** Sections 392.42 and 383.33 of the Federal Motor Carrier Safety Regulations require that you notify your employer the NEXT BUSINESS DAY of any revocation or suspension of your driver's license. In addition, Section 383.31 requires that any time you violate a state or local traffic law (other than parking), you must report it within 30 days to: 1) your employing motor carrier, and 2) the state that issued your license (If the violation occurs in a state other than the one which issued your license). The notification to both the employer and state must be in writing.

The following license is the only one I will possess:

Driver's License No. _____ State _____ Exp. Date _____

DRIVER CERTIFICATION: I certify that I have read and understood the above requirements.

Driver's Name Printed: _____

Driver's Signature: _____ Date: _____

Notes: _____

COMMERCIAL MOTOR VEHICLE DRIVER SAFETY POLICY (Supplement to Employer's Drug-Free Workplace Policies)

The purpose of this policy is to help prevent accidents and injuries resulting from the misuse of alcohol or controlled substances by Drivers of commercial motor vehicles. All employees and owner-operators, if required to have a commercial Driver's license (CDL) under 49 CFR Part 383 (hereinafter referred to as "Drivers"), are subject to these controlled substance and alcohol testing rules established by the Federal Highway Administration (FHWA) under the Omnibus Transportation Employee Testing Act of 1991 (revised February 1994), in accordance with 49 CFR, Parts 40, 382, and § 395.2. With the exception of sanctions for violations of State or local criminal laws applicable to the general public, including Drivers and employers, § 382.109 of these Federal Motor Carrier Safety Regulations preempts any other State or local laws, rules, regulations, or orders which could otherwise obstruct compliance.

Regulatory penalties for infractions described herein are in addition to disciplinary consequences, including possible termination of employment, which may also be imposed by employers for workplace abuse of drugs or alcohol.

ALCOHOL PROHIBITIONS: Drivers shall not report for duty or remain on safety sensitive duties [a] with a breath alcohol concentration of 0.04 or greater, [b] if in possession of alcohol, unless it is listed on the transport manifest, [c] if using alcohol on duty, or [d] if having used alcohol *from any source* within 4 hours of reporting for duty. Drivers found to have breath alcohol concentration of 0.02 or greater, *but less than 0.04*, shall not perform or be permitted to continue to perform safety-sensitive functions until the start of the Driver's next regularly scheduled duty period, but not less than 24 hours following administration the positive alcohol test, unless an interim alcohol test has been administered which registers a breath or saliva alcohol concentration below 0.02.

CONTROLLED SUBSTANCES PROHIBITIONS: Drivers shall not report for duty or remain on safety sensitive duties when using any controlled substance, except when such use is pursuant to the instructions of a licensed physician *who has advised the Driver that the substance does not adversely affect the Driver's ability to safely operate a commercial motor vehicle*. Drivers shall not report for duty, remain on duty or perform safety-sensitive functions when tested positive for illegal controlled substances, until released for return-to-duty by a Substance Abuse Professional, as hereinafter provided. Drivers are prohibited from having bodily concentrations of drugs exceeding threshold levels listed below unless prescribed by a physician.

Amphetamines	1,000 ng/mL	Opiates	2000 ng/mL
Benzoylceogine (Cocaine)	300 ng/mL	Phencyclidine (PCP)	25 ng/mL
Cannabinoids (Marijuana)	50 ng/mL		

REQUIRED TESTS: Drivers are required to submit to controlled substances testing under the following conditions; [1] Pre-employment (§ 382.301), unless, a Driver has been tested under Part 382 Rules within 6 months or subject to Random testing for 12 months preceding application, and verification is obtained from previous employer(s) that violations haven't occurred within 6 months preceding application, [2] Post-accident, (§ 382.303), (a) when either a fatality has resulted, or (b) after receiving a moving vehicle citation linked to an accident *and* bodily injury to a person has *also* occurred requiring immediate medical treatment away from the scene of the accident *and/or* one or more of the vehicles involved incurred disabling damage requiring transport or towing away from the accident scene. [3] Random (§ 382.305), at an initial annualized rate of 50% of all Drivers for controlled substances testing and 10% of all Drivers for alcohol testing, [4] Reasonable Suspicion (§ 382.307), when ordered by a supervisor or company official trained under § 382.603, [5] Return-to-duty (§ 382.309), after engaging in alcohol or controlled substance prohibitions stated in Part 382, Subpart B, and [6] Follow-up (§ 382.311), for a period of up to five (5) years after return to duty, if ordered by a Substance Abuse Professional (SAP).

Pre-employment alcohol testing is no longer required. Subject to certain restrictions, alcohol testing may be performed for any of the other reasons listed for which controlled substance testing may also be required. Alcohol testing may only be performed during periods just before, during, or immediately after

Drivers perform safety sensitive functions which are defined by § 395.2 (*On-Duty Time*) as driving, inspecting, servicing, unloading or loading a motor vehicle.

Both controlled substances and alcohol testing must be performed for all Drivers subject to Post-accident testing. Drivers are to secure a controlled substances test within a maximum of up to 32 hours and an alcohol test within up to 2 hours following the accident. If the required alcohol test cannot be performed within 2 hours, up to a maximum of 8 hours is permitted providing reasons for delay are recorded for review by FHWA upon request. Drivers subject to Post-accident testing may not use alcohol for 8 hours following the accident or until a Post-accident alcohol test has been completed, whichever occurs first. If controlled substance tests cannot be collected within 32 hours and alcohol testing cannot be completed within 8 hours, further attempts to complete the delayed test(s) must cease and reasons testing was not administered must be documented by the employer for review by the FHWA upon request.

Random testing for controlled substances or alcohol must be performed *immediately* after notification of selection unless a Driver is then performing safety-sensitive functions defined by § 395.2, (*On-Duty Time*), in which event, the employer must ensure the Driver safely ceases performing said functions and proceeds for testing as soon as possible.

REFUSAL TO TEST: Drivers *refusing* tests required by DOT Regulations will be subject to the same disciplinary consequences as may otherwise be imposed by an employer for positive test results, and in addition, employers must not permit Drivers refusing to submit to testing to continue to perform safety-sensitive functions. In addition to overt actions or statements, a Driver's refusal to submit to an alcohol or controlled substances test may be determined by [1] failure to provide adequate breath (or saliva) for testing *without a valid medical explanation* after he or she has received notice of the 49 CFR Part 382 requirements for alcohol testing, [2] failure to provide adequate urine for controlled substances testing *without a valid medical explanation* after he or she has received written notice of 49 CFR Part 382 requirements for urine testing, or [3] engaging in conduct that clearly obstructs the testing process.

LAB QUALIFICATIONS: All testing for controlled substances performed in conjunction with this Policy must be conducted in accordance with 49 CFR Part 40. Analysis of urine specimens will be performed only by laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA). Specimen collections will only be performed by qualified collectors trained to follow authorized collection and chain-of-custody protocols.

MEDICAL REVIEW OFFICER PURPOSE/APPEALS: An experienced physician/Medical Review Officer (MRO) will review all negative and confirmed positive lab reports. Positive results may only be reported to employees after the MRO has ascertained that personal prescriptions or other legal substances do not account for the lab findings. Investigations may include, as appropriate, telephone contact with the tested Driver and any prescribing physicians and/or pharmacies identified. Drivers wishing to dispute a controlled substances test result may, at their own expense, within 72 hours of notification of a verified positive test result, request the MRO to order a retest of a split of the original specimen by any SAMHSA certified lab of their choosing.

ALCOHOL TESTING/VERIFICATION: Breath alcohol testing of Drivers must be administered by a Certified Breath Alcohol Technician (BAT) using a calibrated NHTSA approved Evidentiary Breath Testing (EBT) device. Saliva alcohol testing, conducted by a Saliva Testing Technician (STT), has also been approved for initial testing. If positive by *either* method, verification testing, *only using an EBT device*, must be performed within 30 minutes, as required by Part 40.65.

CONSEQUENCES FOR INFRACTIONS: In addition to employer-mandated disciplinary consequences detailed by separate written policy, under Subpart E, Drivers violating alcohol and controlled substances prohibitions stated in Part 382, Subpart B, will be subject to regulatory constraints, including immediate removal from safety sensitive functions such as driving commercial motor vehicles. The offending Driver must be evaluated by a Substance Abuse Professional (SAP) who shall determine what assistance, if any, the Driver needs in resolving problems associated with alcohol misuse and/or illegal controlled substance use. The SAP shall follow the explicit instructions stated in Subpart F, § 382.605 regarding evaluation, referral, and follow up of counseling or treatment for Drivers in violation. Restoration of driving privileges after a negative Return-to-duty test is at the SAP's discretion which could also require successful completion of treatment and Follow-up controlled substances and/or alcohol tests for up to 5 years.

EMPLOYEE ASSISTANCE PROGRAM: An Employee Assistance Program (EAP) is utilized to assist with the implementation of Subpart F - Alcohol Misuse and Controlled Substances Use, Information, Training, and

Referral. The EAP also provides a free, professional, and (by Federal law) *confidential* counseling resource for employee-Drivers with problems concerning alcohol or drugs which could be interfering with their work performance and/or places them in possible violation of Federal Motor Carrier Safety Regulations. Under § 382.601 (b) (11), the EAP will provide information to employees concerning effects of alcohol and controlled substances use on an individual's health, work, and personal life; signs and symptoms of alcohol or controlled substance problems; and available methods of intervening, confronting and referring. In addition, under § 382.603, persons designated by the employer to determine whether reasonable suspicion exists to require a Driver to undergo testing under § 382.307, will receive at least 60 minutes of training on alcohol misuse and an additional 60 minutes on controlled substances abuse.

The employer's EAP is:	Total Compliance Network	EAP Administrator: John Sugg
	3300 University Drive, Suite 903	954-614-0524
	Coral Springs, FL 33065	24 Hours / 7 Days a week
	800-881-4826	

PREVIOUS EMPLOYMENT HISTORY: Under § 382.413, Driver-applicants must provide a prior employment history for a 10-year period preceding application. Drivers must also provide prospective employers with written consent to obtain information from prior employer(s) regarding all positive alcohol and controlled substances test results or refusals to test *covering a 2 year period preceding application*. The prospective employer must obtain this information, by any confidential means, within 14 days of allowing Drivers to assume safety-sensitive positions.

ACKNOWLEDGMENT: By signing below, the Driver acknowledges receiving and understanding this Policy and, under § 382.601, of having also received a copy of Federal Motor Carrier Safety Regulations, Part 382, upon which this Commercial Motor Vehicle Driver Safety Policy is based. Drivers with any questions regarding employer policies or applicable DOT Regulations are encouraged to contact the employer's DOT Information Supervisor, whose name will be posted on employee bulletin board(s) or, alternatively, the EAP may be called. This acknowledgment also authorizes all health care providers to release any information requested by the Medical Review Officer to verify prescription use following a positive controlled substances lab finding.

Print Driver Name	Date	Driver Signature
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REQUEST FOR INFORMATION From Previous Employer

I hereby authorize you to release the following information to McLeod Land Services, Inc. for the purpose of investigation as required by Section 391.23 and allowed by Section 383.35 of the Federal Motor Carrier Safety Regulations. You are released from any and all liability, which may result from furnishing information.

Date: _____ Applicant's Signature: _____

Name and Address of
Previous Employer:

Fill in appropriate space:

_____ Date mailed _____

_____ Date faxed _____

_____ Phone validation date _____

_____ Name of contact _____

TO BE FILLED OUT BY PREVIOUS EMPLOYER

Dear Sir/Madam:

The below named individual has made application to this company for a position as _____
_____ and states that he/she was employed by you as _____
_____ from (m/y) _____ to (m/y) _____.

We appreciate your time in completing, in confidence, the information requested below. Enclosed is a business reply envelope for you convenience. Thank you for your courtesy.

Sincerely, _____

Name of applicant: _____

Social security number: _____

Employed from (m/y) _____ to (m/y) _____

As _____ with a wage or salary at _____

Did he/she operate a vehicle or equipment for you _____ Please specify type _____

Was he/she a safe and efficient driver? _____ What was the reason for leaving your employ? _____

Discharged: _____ Resignation: _____ Lay off: _____ Military duty: _____

Please explain: _____

Was his/her general conduct satisfactory? _____

Please advise history of past driving record if available for the past three years: _____

CONFIDENTIAL REPORT OF PERSONAL REFERENCE

Please indicate your opinion by placing a check mark in the appropriate space.

Characteristics	Excellent	Good	Fair	Poor
Disposition, Tact, Ability to Get along with others	_____	_____	_____	_____
Initiative, Resourcefulness	_____	_____	_____	_____
Safety Habits	_____	_____	_____	_____
Driving Skill	_____	_____	_____	_____
Attitude	_____	_____	_____	_____
Loyalty	_____	_____	_____	_____
Dependable	_____	_____	_____	_____

Any other remarks: _____

Signature: _____

Title: _____

Date: _____

FOR PROSPECTIVE EMPLOYER'S RECORD
MAINTIAN THIS INFORMATION IN THE DRIVER QUALIFCATION FILE FOR
3 YEARS AFTER THE PERSON'S EMPLOYMENT BY THE MOTOR CARRIER CEASES.