

# APPLICATION FOR EMPLOYMENT

COMPANY \_\_\_\_\_ STREET ADDRESS \_\_\_\_\_

CITY, STATE AND ZIP CODE \_\_\_\_\_

NAME \_\_\_\_\_ (FIRST) (MIDDLE) (Maiden Name, if any) (LAST)

ADDRESS \_\_\_\_\_ (STREET) (CITY) (STATE & ZIP CODE) HOW LONG? \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ HIRE DATE \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

## PREVIOUS THREE YEARS RESIDENCY

(STREET) (CITY) (STATE & ZIP CODE) # YEARS \_\_\_\_\_

(STREET) (CITY) (STATE & ZIP CODE) # YEARS \_\_\_\_\_

(STREET) (CITY) (STATE & ZIP CODE) # YEARS \_\_\_\_\_

(ATTACH SHEET IF MORE SPACE IS NEEDED)

## LICENSE INFORMATION

Section 383.21 FMCSR states "No person who operates a commercial motor vehicle shall at any time have more than one driver's license". I certify that I do not have more than one motor vehicle license, the information for which is listed below.

STATE	LICENSE NO.	TYPE	EXPIRATION DATE

## DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.)	FROM	DATES	TO	APPROX. NO. OF MILES (TOTAL)
STRAIGHT TRUCK					
TRACTOR AND SEMI-TRAILER					
TRACTOR - TWO TRAILERS					
OTHER					

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED)

DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	NUMBER FATALITIES	NUMBER INJURIES	CHEMICAL SPILLS
				YES NO
				YES NO
				YES NO

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

DATE CONVICTED (month/year)	VIOLATION	STATE OF VIOLATION LOCATION	PENALTY (forfeited bond, collateral and/or points)

(ATTACH SHEET IF MORE SPACE IS NEEDED)

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES \_\_\_\_ NO \_\_\_\_

If yes, explain \_\_\_\_\_

B. Has any license, permit or privilege ever been suspended or revoked? YES \_\_\_\_ NO \_\_\_\_

If yes, explain \_\_\_\_\_

**EMPLOYMENT RECORD**  
(ATTACH SHEET IF MORE SPACE IS NEEDED)

Applicants that desire to drive in intrastate/interstate commerce must provide the following information on all employers during the previous three years. You must give the same information for all employers you have driven a commercial motor vehicle for the seven years prior to the initial three years (total of ten years employment record).

Must list the complete mailing address: street number and name, city, state and zip code.

**LAST EMPLOYER: NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**POSITION HELD** \_\_\_\_\_ **FROM** \_\_\_\_\_ **TO** \_\_\_\_\_ **SALARY** \_\_\_\_\_

**REASONS FOR LEAVING** \_\_\_\_\_

**ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON.** \_\_\_\_\_

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes No

Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes No

**SECOND LAST EMPLOYER: NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**POSITION HELD** \_\_\_\_\_ **FROM** \_\_\_\_\_ **TO** \_\_\_\_\_ **SALARY** \_\_\_\_\_

**REASONS FOR LEAVING** \_\_\_\_\_

**ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON.** \_\_\_\_\_

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes No

Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes No

**THIRD LAST EMPLOYER: NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**POSITION HELD** \_\_\_\_\_ **FROM** \_\_\_\_\_ **TO** \_\_\_\_\_ **SALARY** \_\_\_\_\_

**REASONS FOR LEAVING** \_\_\_\_\_

**ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON.** \_\_\_\_\_

Were you subject to the Federal Motor Carrier Safety Regulations (FMCSRs) while employed by the previous employer? Yes No

Was the previous job position designated as a safety sensitive function in any DOT regulated mode, subject to alcohol and controlled substances testing requirements as required by 49 CFR Part 40? Yes No

**TO BE READ AND SIGNED BY APPLICANT**

I authorize you to make sure investigations and inquiries to my personal, employment, 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 of employment has been extended.) I hereby release employers, schools, health care providers and other persons from all liability in responding to inquiries and releasing information in connection with my application.

In the event of employment, I understand that false or misleading information given in my application or interview(s) 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 employer(s) 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 current/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.

\_\_\_\_\_ **DATE**

\_\_\_\_\_ **APPLICANT'S SIGNATURE**

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

\_\_\_\_\_ **DATE**

\_\_\_\_\_ **APPLICANT'S SIGNATURE**

Note: A motor carrier may require an applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.



## COMMERCIAL DRIVER QUESTIONNAIRE #11

1. POLICYHOLDER'S NAME			
POLICYHOLDER'S ADDRESS			
2. DRIVER'S FIRST NAME		MIDDLE INITIAL	LAST NAME
LICENSE NUMBER		STATE	Prior State And Operator's Number If Less Than 3 Years
COMMERCIAL DRIVER'S LICENSE		DATE HIRED	JOB TITLE
DRIVER'S COMPANY		HOME PHONE NUMBER	
3. WARNING: An incorrect answer, intentional or not, to any question below may jeopardize continuing coverage. If the answers to any of the following are "Yes," give details in space provided.			
Has driver:			
(a) Had any auto insurance refused, cancelled or expired in the past 5 years? or been excluded or restricted on a policy in the past 5 years? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OHIO ONLY: Had any auto insurance refused, cancelled or expired for: (1) Material misrepresentation in application or in submission of claims? <input type="checkbox"/> (2) Suspension, revocation or expiration of operator's license of named insured or principal operator? <input type="checkbox"/>			
(b) Been required to file evidence of financial responsibility in the past 5 years? <input type="checkbox"/>			
(c) Had their driver's license or driving privileges revoked or suspended in the past 5 years? (Give date and reason.) <input type="checkbox"/>			
(d) Received a ticket for speeding, a PBJ (PJC in NC), or any other vehicle code violation within the past 5 years? (If "Yes," give date and description of violation(s). If speeding, include your actual speed and the speed limit.) <input type="checkbox"/>			
(e) Ever receive any felony convictions? Give date, description and penalty. <input type="checkbox"/>			
(f) Had a physical or mental impairment or disability or other medical infirmity? Identify any such condition (e.g., heart, diabetes, epilepsy, hearing, sight or limb loss, back condition or other medical infirmity), its duration and treatment obtained and/or medication prescribed. <input type="checkbox"/>			
(g) Had any comprehensive losses (deer, fire, glass breakage, theft, etc.) in the past 5 years? <input type="checkbox"/>			
(h) While driving any motor vehicle, commercial or personal, been involved in an accident during the past 5 years? <input type="checkbox"/>			
Describe all accidents regardless of who was at fault under No. 8 below.			
(i) FOR MD ONLY: Refused to submit to a chemical test or been given probation before judgment for an alcohol violation in the past 3 years? <input type="checkbox"/> (NOTE FOR DC ONLY: Question 3(a) not applicable. For questions (b), (c), (d), (g), (h) & (i), ask for 3 year record only.)			
(NOTE FOR MD ONLY: For Questions 3 (a), (b), (c), (d), (g), (h) & (i) ask for 3 year record only.)			
(NOTE FOR WH ONLY: Question 3(f) not applicable.)			
Details for "Yes" answers:			
4. List driver's previous experience driving types of commercial vehicles insured and any safety courses completed			
5. Does driver take home any company autos on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what vehicle(s)			
6. Does driver have any restrictions on license? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what are the restrictions?			
7. Were MVRs/CLUES ordered on any/all drivers? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," attach copies.			
8. OTHER PERTINENT INFORMATION			
AGENT: Do you consider this an acceptable risk? <input type="checkbox"/>			
Agent's Signature			

DEFRAUDING INSURER	<p>WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.</p> <p>Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p>
APPLICATION FOR INSURANCE	<p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.</p>
INSURANCE FRAUD	<p>Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.</p>
APP. FOR INSURANCE	<p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.</p>
DEFRAUDING COMPANY	<p>It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.</p>
DEFRAUDING INSURER	<p>Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p>
DEFRAUDING INSURER	<p>Any person who knowingly files an application containing any false, incomplete or misleading information, may be subject to criminal and/or civil penalties.</p>

<p>I certify that I have given true and complete answers to the above questions. You have my permission to obtain a copy of my motor vehicle driving record for purposes of determining my eligibility for coverage under this policy.</p>	
SIGNATURE	DRIVER'S SIGNATURE _____ Date _____
POLICYHOLDER'S (OR AUTHORIZED REPRESENTATIVE'S) SIGNATURE _____	Date _____
Title _____	

# DRIVER APPLICANT DRUG AND ALCOHOL PRE-EMPLOYMENT STATEMENT

CFR Part 40.25(j) requires the employer to ask any applicant, whether he or she has tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which the employee applied for, but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol rules during the past two years. If the potential employee admits that he or she had a positive test or refusal to test, we must not use the employee to perform safety-sensitive functions, until and unless the potential employee provides documentation of successful completion of the return-to-duty process. (See Section 40.25(b)(5) and (e).

Applicant Name: \_\_\_\_\_ ID Number: \_\_\_\_\_  
(Please Print)

As an applicant, applying to perform safety-sensitive functions for our company, you are required by CFR Part 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 DOT agency drug and alcohol testing rules during the past two years?  
Yes  No
2. If you answered yes, to the above question, can you provide proof that you have successfully completed the DOT return-to-duty requirements?  
Yes  No

My signature below certifies that the information provided is true and correct.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form is courtesy of:



TO:

It is understood that my job position/employment requires me to drive a (company owned vehicle)(my own car on company business). I understand that the insurance company writing your automobile insurance requires a copy of my current driving record to assess my insurability. I also understand I have the right to see a copy of my Motor Vehicle Report.

By this letter I hereby authorize the insurance company and/or its agent to obtain the necessary motor vehicle records.

(Printed Name of Employee) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Drivers License Number: \_\_\_\_\_

State License is issued in: \_\_\_\_\_

Date of Birth: \_\_\_\_\_