APPLICATION FOR INDEPENDENT CONTRACTORS

INSTRUCTIONS (Read Carefully)

This application must be completed in full. Leave no spaces blank.

In the "PAST EMPLOYMENT" section, you must go back ten (10) years. Account for all time. Be sure to list phone numbers and complete addresses for each past employer. If an employer listed is no longer in business, you must be able to furnish QFS Transportation LLC. with proof of employment with that employer. If you need more space for past employment listings, extra sheets are available.

THE INFORMATION HEREIN REQUESTED IS PURSUANT TO THE REGULATIONS OF THE U.S. DEPARTMENT OF TRANSPORTATION

DATE: ____________________________

1. TO BE QUALIFIED AS A DRIVER FOR: (Independent Contractor): ______QFS TRANSPORTATION____________
2. FULL NAME: ____
   (Last) (First) (Middle)
3. SOCIAL SECURITY NUMBER: _________-___________-__________ FED ID NUNBER: ________-______________________
4. DATE OF BIRTH: ___________/_________/_____________ EMAIL ADDRESS: _______________________________________
   (Month) (Day) (Year)
5. PRESENT ADDRESS: ____
   (Street or route) (City) (State) (Zip)
6. HOW LONG AT THE ABOVE ADDRESS? YEARS ________ MONTHS ________ EMAIL: _______________________________________
7. PHONE/CELL NUMBER (including area code): _____________-___________________
   (Area Code) (Number)
8. IN CASEOF EMERGENCY PLEASE NOTIFY: ____
   (Name)
9. RELATION TO YOU? ________________________________ PHONE NUMBER: _____________________________________
10. IF YOU HAVE BEEN AT THE ABOVE ADDRESS **LESS THANK THREE (3) YEARS,** PLEASE LIST ALL PREVIOUS ADDRESSES YOU HAVE LIVED AT FOR THE **LAST THREE (3) YEARS:**

    ____ HOW LONG? YEARS _____ MONTHS ______
    (Street or route) (City) (State) (Zip)

    ____ HOW LONG? YEARS _____ MONTHS ______
    (Street or route) (City) (State) (Zip)
11. LAST GRADE COMPLETED IN SCHOOL: ___________/________________________________/______________________
    (Grade) (School) (Year)
12. LIST YOUR CURRENT DRIVERS LICENSE: ____
    (State) (Type/Class) (Number) (Expiration Date)

REQUIRED DOCUMENTS FOR DRIVER APPLICATIONS

Copy of CDL **Copy of social security card** **Copy of long form physical** **Copy of medical Card**

13. LENGTH OF TIME DRIVING ANY TYPE MOTOR VEHICLE ______YEARS ______MONTHS
14. LENGTH OF TIME DRIVING ANY COMMERCIAL VEHICLE ______YEARS ______MONTHS
15. LENGTH OF TIME DRIVING TRACTOR-TRAILERS ______YEARS ______MONTHS
16. LENGTH OF TIME DRIVING OVER THE ROAD ______YEARS ______MONTHS
17. LENGTH OF TIME CITY DRIVING ______YEARS ______MONTHS
18. LENGTH OF TIME SPOTTING ______YEARS ______MONTHS
19. LIST THE MAKES OF TRACTORS DRIVEN:

    ____
20. TWIN SCREW: __________ SINGLE AXLE:__________ CONVENTIONAL:_________ SLEEPER:_________ COE:_____________
21. LIST THE TYPES OF TRANSMISSIONS:

    ____
22. TYPES OF TRAILERS: 35' ________________ 40'_______________ OTHER:________________________
23. KIND OF FREIGHT HAULED: GENERAL: ____________ REFRIGERATED: ______________ STEEL: ________________
    HAZARDOUS: ____________ TANKER: ______________ OTHER:____

PAST EMPLOYMENT RECORD

ACCOUNT FOR ALL TIME N PAST TEN (10) YEARS (NO GAPS) & WHETHER YOU WERE SUBJECT TO FMCSR'S & DRUG & ALCOHOL TESTING 2 YEAR MINIMUM OF OVER-THE-ROAD TRACTOR/TRAILER VERIFIABLE EXPERIENCE
(List present job first and past jobs following in chronological order)

Company Name:____ Supervisor:____

Address:____ Phone:____

City State Zip:____ From: Mo. _________ Yr. ________ to Mo._________ Yr.________

Position Held: ____

Reason for Leaving:_______________________________________ Total years and months spent at this job: _____________________

DID THIS JOB REQUIRE A CLASS A CDL? ____ Yes _____ No

WERE YOU UNDER THE RULES OF THE FMCSR AT THIS JOB? ___ Yes ____ No

DID YOU HAVE TO DRUG AND/OR ALCOHOL TEST AT THIS JOB? ___ Yes ___ No

Company Name:____ Supervisor:____

Address:____ Phone:____

City State Zip:____ From: Mo. _________ Yr. ________ to Mo._________ Yr.________

Position Held: ____

Reason for Leaving:_______________________________________ Total years and months spent at this job: _____________________

DID THIS JOB REQUIRE A CLASS A CDL? ____ Yes _____ No

WERE YOU UNDER THE RULES OF THE FMCSR AT THIS JOB? ___ Yes ____ No

DID YOU HAVE TO DRUG AND/OR ALCOHOL TEST AT THIS JOB? ___ Yes ___ No

Company Name:____ Supervisor:____

Address:____ Phone:____

City State Zip:____ From: Mo. _________ Yr. ________ to Mo._________ Yr.________

Position Held: ____

Reason for Leaving:_______________________________________ Total years and months spent at this job: _____________________

DID THIS JOB REQUIRE A CLASS A CDL? ____ Yes _____ No

WERE YOU UNDER THE RULES OF THE FMCSR AT THIS JOB? ___ Yes ____ No

DID YOU HAVE TO DRUG AND/OR ALCOHOL TEST AT THIS JOB? ___ Yes ___ No

Company Name:____ Supervisor:____

Address:____ Phone:____

City State Zip:____ From: Mo. _________ Yr. ________ to Mo._________ Yr.________

Position Held: ____

Reason for Leaving:_______________________________________ Total years and months spent at this job: _____________________

DID THIS JOB REQUIRE A CLASS A CDL? ____ Yes _____ No

WERE YOU UNDER THE RULES OF THE FMCSR AT THIS JOB? ___ Yes ____ No

DID YOU HAVE TO DRUG AND/OR ALCOHOL TEST AT THIS JOB? ___ Yes ___ No

PAST EMPLOYMENT RECORD
ACCOUNT FOR ALL TIME N PAST TEN (10) YEARS (NO GAPS) & WHETHER YOU WERE SUBJECT TO FMCSR'S & DRUG & ALCOHOL TESTING 2 YEAR MINIMUM OF OVER-THE-ROAD TRACTOR/TRAILER VERIFIABLE EXPERIENCE
(List present job first and past jobs following in chronological order)

Company Name:____ Supervisor:____

Address:____ Phone:____

City State Zip:_______________________________________ From: Mo. _________ Yr. ________ to Mo._________ Yr.________

Position Held: ____

Reason for Leaving:___________________________________ Total years and months spent at this job: _____________________

DID THIS JOB REQUIRE A CLASS A CDL? ____ Yes _____ No

WERE YOU UNDER THE RULES OF THE FMCSR AT THIS JOB? ___ Yes ____ No

DID YOU HAVE TO DRUG AND/OR ALCOHOL TEST AT THIS JOB? ___ Yes ___ No

Company Name:____ Supervisor:____

Address:____ Phone:____

City State Zip:_______________________________________ From: Mo. _________ Yr. ________ to Mo._________ Yr.________

Position Held: ____

Reason for Leaving:___________________________________ Total years and months spent at this job: _____________________

DID THIS JOB REQUIRE A CLASS A CDL? ____ Yes _____ No

WERE YOU UNDER THE RULES OF THE FMCSR AT THIS JOB? ___ Yes ____ No

DID YOU HAVE TO DRUG AND/OR ALCOHOL TEST AT THIS JOB? ___ Yes ___ No

Company Name:____ Supervisor:____

Address:____ Phone:____

City State Zip:_______________________________________ From: Mo. _________ Yr. ________ to Mo._________ Yr.________

Position Held: ____

Reason for Leaving:___________________________________ Total years and months spent at this job: _____________________

DID THIS JOB REQUIRE A CLASS A CDL? ____ Yes _____ No

WERE YOU UNDER THE RULES OF THE FMCSR AT THIS JOB? ___ Yes ____ No

DID YOU HAVE TO DRUG AND/OR ALCOHOL TEST AT THIS JOB? ___ Yes ___ No

Company Name:____ Supervisor:____

Address:____ Phone:____

City State Zip:_______________________________________ From: Mo. _________ Yr. ________ to Mo._________ Yr.________

Position Held: ____

Reason for Leaving:___________________________________ Total years and months spent at this job: _____________________

DID THIS JOB REQUIRE A CLASS A CDL? ____ Yes _____ No

WERE YOU UNDER THE RULES OF THE FMCSR AT THIS JOB? ___ Yes ____ No

DID YOU HAVE TO DRUG AND/OR ALCOHOL TEST AT THIS JOB? ___ Yes ___ No

THE FOLLOWING QUESTIONS PLEASE ANSWER YES OR NO. IF, YES PLEASE GIVE AN EXPLANATION BELOW WITH THE CORRESPONDING NUMBER:

24. Do you posses a valid U.S. Department of Transportation long form physical? ____ Yes ____ No
25. Have you ever received a safe driving award? ____ Yes ____ No
26. Have you ever received workers' compensation? ____ Yes ____ No
27. Do you have any defects in hearing? ____ Yes ____ No
28. Do you have any defects in vision? ____ Yes ____ No
29. Do you have any defects in speech? ____ Yes ____ No
30. Have you ever had any physical or mental disorders that would disqualify you from Driving under DOT regulations? ____ Yes ____ No
31. Were you ever discharged by an employer because of an accident? ____ Yes ____ No
32. Have you ever been convicted of any crime or felony? ____ Yes ____ No
33. Have you ever been known by any name other than the one on this application? ____ Yes ____ No
34. Have you tested positive or refused to test on any pre-employment alcohol and drug test administered by an employer to which you applied but were not hired during the past 2 years? ____ Yes ____ No
35. Has your license ever been revoked, suspended or denied in any state? ____ Yes ____ No
36. If you answered **YES** to any of the above question please give an explanation below.
    (If more space is needed for explanation, write on a separate piece of paper) (Question#) (IE: EXAMPLE: 16-Safe driving award ABC Inc. for 01, 02, 03)

    ____

    ____

37. List convictions or forfeiture of bond, if any, for violation of any criminal law:

    OFFENSE DATE CITY/STATE DISPOSITION

    ____

    ____

38. List all vehicular accidents for the past three (3) years, preventable or non-preventable, in which you were involved:

    Date City/State Description Type of Vehicle Injuries/Fatalities

    ____

    ____

    ____

39. List any and all tickets or arrests for any motor vehicle law violations for the past three (3) years:

    ____

    ____

*****TO BE READ AND SIGNED BY APPLICANT*****

It is agreed and understood that any misrepresentations of information given in this application shall be considered as an act of dishonesty. It is agreed and understood that its agents may investigate the applicant's background to ascertain any and all information of concern to applicant's record, whether same as record or not, and applicant releases employers and persons name herein from all liability for any damages on account of his/her furnishing such information. The applicant agrees to furnish such additional information and complete such examinations as may be required to complete his/her file. It is agreed and understood that this application in no way obligates to approve the application. However, it is agreed and understood that if approved, the applicant may be on a probationary period during which time he/she may be released without recourse. 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.

Date: ________________________ Signature of Applicant: ____

WITENESSED BY: (Terminal Agent): ____

MOTOR VEHICLE DRIVERS' CERTIFICATION OF VIOLATIONS

MOTOR CARRIER INSTRUCTIONS: Each motor carrier shall, at least once every twelve (12) months, require each driver to prepare and furnish it with a list of all violations of motor vehicle traffic laws and ordinances (other than violations involving only parking) of which the driver has been convicted, or an account of which he has forfeited bond or collateral during the preceding twelve (12) months. (Section 391.27)

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 shall so certify. (Section 391.27)

I certify that the following is true and complete list of traffic violations (other than parking violations) for which I have been convicted or forfeited bond or collateral during the past twelve 12 months.

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 required to be listed during the past twelve (12) months.

Driver's License No. ________________________________ State _________________ Expiration Date __________________

____ ______________________
Driver's Signature Date

____
Driver's printed name

QFS TRANSPORTATION LLC
(Motor Carrier's Name)

1224 BELLVIEW DRIVE, GREENDALE, IN 47025
(Motor Carrier's Address)

____
(Reviewed by: Signature of Company Official)

SAFETY
(Title)

7- DAY PREVIOUS LOG

Instructions: Motor carriers 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(r) Federal Motor Carrier Safety Regulations.

DAY	1	2	3	4	5	6	7	TOTAL
DATE								
HOURS WORKED								

I hereby 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) (Day) (Month) (Year)

Signature: ____

Witness: ____ Date: _______________________

POLICY AGREEMENT

I, the undersigned, certify that I have read and understand the Company's Statement of Policy on Drug and Alcohol Abuse and have received a copy of that policy.

By accepting employment or qualification or contractual agreement with the Company, I also consent to submit to screening for drugs and/or alcohol and controlled substances and I agree to comply with all of the requirements of the Company, the Federal Motor Carrier Safety Regulations and any federal, state or local laws and rules governing the use or abuse of alcohol, drugs and controlled substances.

I understand that my failure to honor the terms of this agreement will be grounds for termination of my qualification, and/or my contractual agreement with the Company.

Driver's Initials_________________

FMCSA Notification of Driver Rights

In compliance with 49 CFR Part 391.23, you have certain rights regarding the performance history information that will be provided to prospective employers. I) You have the right to review information provided by previous employers. II) You have the right to have errors in the information corrected by the previous employer and for that previous employer to re-send the corrected information to prospective employers. III) You have the right to have a rebuttal statement attached to the alleged erroneous information, if the previous employer and the driver cannot agree on the accuracy of the information. (2) Drivers who have previous DOT regulated employment history in the preceding three years and wish to review previous employer-provided investigative information must submit a written request to prospective employers. This may be done at any time, including when applying, or as late as 30 days after being employed or being notified of denial of employment. Prospective employers must provide this information within five business days of receiving the written request. If prospective employers have not yet received the requested information from the previous employer, then the five-day deadline will begin when the requested safety performance history information is received. If you have not arranged to pick up or receive the requested records within 30 days of prospective employers making them available, prospective employers may consider you to have waived your request to review the record.

Driver's Initials _________________

Rules and Procedures

This is to certify that I have been through orientation on the following rules, regulations and procedures and that I have received EAP training on controlled substances:

DRUG AND ALCOHOL ABUSE POLICY AND EDUCATION

UNAUTHORIZED PASSENGERS

LOG AND HOURS OF SERVICE REGULATION

VEHICLE INSPECTION PROCEDURES

HAZARDOUS MATERIALS AND REGULATIONS

This is to certify that I have received and do fully understand the rules and procedures for Independent Contractors. I have also had compensation procedures explained and I understand them.

I acknowledge receipt of the Federal Motor Carrier Safety Regulations, and I agree to familiarize myself with parts 325, 382, 383, 386, 387 and 390-399 Subchapter 3, Chapter 3, Title 49 of the Code of Federal Regulations.

According to the D.O.T. interpretations, every carrier must adopt and enforce a MEAL STOP POLICY in accordance with Line # 1, OFF-Duty, and maintain a copy of this policy with the driver's signature in his/her personnel file. One (1) hour off-duty is allowed for a meal stop in ten (10) hour driving period. This may be taken in two (2) one-half (1/2) hour segments.

I DO ACKNOWLEDGE THAT I HAVE READ AND DO UNDERSTAND THE ABOVE POLICIES AND PROCEDURES. I FURTHER UNDERSTAND THAT NON-COMPLIANCE AND/OR VIOLATIONS OF ANY OF THE ABOVE RULES WILL RESULT IN IMMEDIATE CORRECTIVE ACTION.

Driver's Initials _________________

Log Policies

In our ongoing attempt to keep our company's safety standards, we are asking for your support. Please be aware that the safety department audits roadside inspections and logs to improve standards and have set new goals for us to meet. When completing a driver log, please make sure that:

Drivers are logging fuel stops, logging "fuel" and the city

Drivers are logging DOT roadside inspections, logging "dot inspections" and the city

Drivers are logging Random Drug Screen time

Drivers are logging in and out gate times and the city

These are being logged as "on duty not driving"

We feel that keeping logs up to date and accurate is a major step toward reducing out-of-service violations on roadside inspections. We are monitoring for major violators and repeat offenders, and if deemed necessary, we will spend a day training said violators. **Also, a trend has been noticed: Many drivers are not taking the 10 consecutive hours off duty to reset the 14-hour clock. This leads to hours of service violations.** Understand that this is to reduce the likelihood of being inspected by a DOT official. Also be advised that drivers need to turn a copy of the roadside into corporate. Otherwise, we order the reports from the state for a fee. The fee will be charged back to the driver. Please have all drivers sign and return this form, acknowledging our goals and expectations.

Driver's Initials _________________

Safety Policy

The efficiency of any operation can be measured directly by its ability to control loss. Accidents resulting in personal injury, damage to property and equipment represents needless suffering and waste. It is the responsibility of the management of this company to assure the safest conditions and equipment for all independent contractors. The company policy on safety is:

(1) The safety of the independent contractors, the public and the operations is paramount. Every effort will be made to eliminate hazards and reduce the possibility of accidents and injuries.

(2) Safety will be given priority over expediency and shortcuts.

(3) The company, its' managers, independent contractors, and owner/operators will comply with all safety laws and regulations.

(4) **No passengers or ride-alongs are permitted while under dispatch.**

Every manager, independent contractor and owner/operator will be expected to demonstrate attitudes and actions which reflect this policy for their own safety and for the safety of others. I understand and agree to the Safety Policy.

Driver's Initials _________________

Accident Procedures

In the event you are involved in any accident, on private property or public roads **you must call the company at 888-665-4904 Option 6** and ask for **Safety.** They can be reached at this number 24-7. It is imperative that they are contacted at the scene of the accident to guide you through the proper steps to ensure safety of all parties and lessen the liability for you, and the company. Enclosed is a complete accident procedure, accident report, and witness cards. In case accident requires you to be drug and alcohol tested, enclosed are instructions for the collection site, a chain of custody, mailing label, and an airborne express lab pack. Please keep this in your truck at all times. If you use or lose this packet, please ask your terminal manager for another.

CALL IMMEDIATELY FROM THE SCENE—888-665-4904 Option 6

DRIVER MUST ALWAYS PERFORM A POST ACCIDENT AND DRUG AND BREATH ALCOHOL TEST WITHIN TWO HOURS OF THE ACCIDENT.

I have read and understand the Accident Policy. **Driver's Initials** _________________

No Hazmat Policy

This is to certify that I, ____, understand and acknowledge that while I am leased to **QFS Transportation**, I will, under no circumstances, transport any HAZARDOUS MATERIALS.

Driver's Initials _________________

Your tractor must be properly registered for "IRP" to enter each state.

It is your responsibility to make sure all permits, licenses, and authorities are properly displayed, maintained, and not expired. If you are dispatched into any other state, call immediately for instructions, temporary permits may be needed. You are responsible to make sure you are legally permitted at all times.

Driver's Initials _________________

One License Rule

ALL DRIVERS: PLEASE READ THE FOLLOWING STATEMENT. IF IT IS CORRECT AS IT APPLIES TO YOU, PLEASE INITIAL ON THE LINE.

Verified Statement

I certify, under penalty of the laws of the United States of America, that I do not hold any driver's licenses other than the one from my state of domicile. Further, I certify that I know that any false, fictitious or fraudulent statement or representation may be punishable under 18 U.S.C. 1001, which provides for fines up to $10,000.00, imprisonment up to 5 years, or both.

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.

Driver's Initials__________________

I have received the above and understand my responsibilities.

Tractor Unit # ______________________________ Date: ___________________________________

Printed Name: ____

Signed Name: ____

Request for Driver's Safety Performance History
Information from Dot Regulated Previous Employer(s)

Carrier Name: QFS Transportation LLC

Contact Person: Safety Department

Address: *1224 Bellview Drive*

City, State, Zip: *Greendale, IN 47025*

Phone: *812-307-4677*

Confidential Fax: *812-496-0366*

Email: *voe@qfstransportation.com*

Driver to Sign this section only

As a Commercial Motor Vehicle (CMV) Driver, I understand that per, the Federal Motor Carrier Safety Regulations (FMCSRs) Part 391.21, the following information will be requested from all previous employers for which I operated a CMV, subject to the FMCSR Parts 390 and/or 40, 382 & 383, *within the past three years,* from the date shown below. I also acknowledge that this information will be used in determining my eligibility to be hired, that I have the right to review this information and rebut any errors in these statements from my prior employers, as described in the FMCSR Part 391.23.

I, _________________________, hereby authorize this company to release all records of employment, including assessments of my job
Print name
performance, ability and fitness, including dates of any and all alcohol or drug tests. Those confirmed results and/or my refusal to submit to any alcohol or drug tests and any rehabilitation completion under direction of (SAP/MRO) to each and every company (or their authorized agents) which may request such information in connection with my application for employment with said company. I hereby release this company, and its independent contractors, officers, directors, and agents from any and all liability of any type as a result of providing information to the above -mentioned persona and/or company.

Previous Employer:____

Contact Person: ___________________________________

Mailing Address: ____

City, State, Zip:___________________________________

Telephone Number: ____

Fax Number:_______________________________________

I worked for this company from the date of ____/____/____ to ____/____/_____

Applicant's Signature SSN or Id Number D.O.B. Today's Date

SECTION I – Past Employer to Complete >> DRUG & ALCOHOL INFORMATION

Please provide the following drug and alcohol information as required by FMCSR Part 391.23 & 40.25. If no drug and alcohol information is available on above-named applicant check here. ☐

	YES	NO
1. Any Alcohol test with a result of 0.04 or higher alcohol concentration?		
2. Any verified positive drug test?		
3. Any refusals to be tested (including verified adulterated or substituted drug test results)?		
4. Any other violation of DOT agency drug and alcohol testing regulations (Part 382 or Part 40)?		
5. If this driver did successfully complete a SAP rehabilitation referral and remained in your employ, did he/she have any subsequent violations for: an alcohol test result of 0.04 or greater, a verified positive drug test or a refusal to test (including a verified adulterated/substituted drug test result)?		

6. If yes to any of the above questions, please provide documentation of successful completion of an SAP evaluation, prescribed treatment and return-to-duty requirements (including follow-up tests) if they remained in your employ*.

***If this information is not available from the previous employer, you as a prospective employer, must get this information from the driver/applications.**

Drug and alcohol information needs to be kept in a separate personnel and/or confidential file.

ACCIDENT PROCEDURES

In the event you are involved in **any accident,** on private property or public roads you **must call** QFS Transportation Corporate office at **888-665-4904 (option 6) and ask for Todd Hammerstrom.** This number should be called 24-7 to report ALL accidents or incidents. It is imperative that QFS Corporate office is contacted while the driver is at the scene of the accident to guide the driver through the proper steps to ensure safety of all parties and lessen the liability for the driver, and the company. You will receive a complete accident procedure, accident report and witness cards. In case accident requires you to be drug and alcohol tested, there are also instructions for the collection site, a chain of custody, mailing label and express lab pack. Please keep this in your truck at all times. If you use or lose this packet, please ask your terminal manager for another.

CALL IMMEDIATELY FROM THE SCENE
888-665-4904 OPTION 6
ASK FOR TODD HAMMERSTROM

DRIVER MUST ALWAYS PERFORM A POST ACCIDENT DRUG & BREATH ALCOHOL TEST WITHIN TWO HOURS OF THE ACCIDENT WHEN AN ACCIDENT IS DOT REPORTABLE. TODD HAMMERSTROM WILL INSTRUCT THE DRIVER REGARDING TESTING!

I have read and understand the company's accident policy.

Driver Signature: ____ Date: ______________________

PREVIOUS PRE-EMPLOYMENT
ALCOHOL AND DRUG TEST STATEMENT

Sec. 40.25(j) As the employer, you must also ask the independent contractor 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 independent contractor 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 independent contractor admits that he or she had a positive test or a refusal to test, you must not use the independent contractor to perform safety-sensitive functions for you, until and unless the independent contractor documents successful completion of the return-to-duty process (see paragraphs (b)(5) and (e) of this section

Prospective Independent contractor Printed Name:
____

Prospective Independent contractor SS or ID Number:
____

The prospective independent contractor 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 DOT agency drug and alcohol testing rules during the past two (2) years?

   _____ Yes   _____ No

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

   _____ Yes   _____ No

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

Prospective Independent contractor Signature: ______________________________________
Date:___________________

Witness Signature: ____ Date: ___________________

Record retention guidelines:
If "yes" to question 1, retain this form and documentation provided for 5 years.
If "no" to question 1, discard after employment terminates but not less than 2 years from the date of statement.

COMBINED DISCLOSURE NOTICE AND AUTHORIZATION REGARDING BACKGROUND CONSUMER REPORTS

(Important: Please read carefully before signing)

The Fair Credit Reporting Act requires that we inform you that a background investigation may be conducted as part of our screening and hiring process. This may include an inquiry to obtain information regarding your character, employment history, general reputation, personal characteristics, police record, education, qualifications, motor vehicle record, mode of living and/or credit and indebtedness. The primary objective of any investigation will be to verify information you provided on your application or during the interview process in connection with your application for and/or continued employment (or contract) with the company. A consumer report and/or an investigative consumer report may be obtained at any time during the application process or during your employment with the company. Upon timely written request to our personnel department, and within 5 days of the request, the name, address and phone number of the reporting agency and the nature and scope of the report (if one is made) will be provided to you. You have the right to request details of the report from the consumer-reporting agency. Before any adverse action is taken, based in whole or in part on the information contained in the consumer report, you will be proved a copy of the report, the name, address and telephone number of the reporting agency, a summary of your rights under the Fair Credit Reporting Act, as well as additional information on your rights under the law. The items of information requested below are required to process your background investigation. They are intended solely for that purpose and will not be used in a discriminatory manner for the making of business decisions.

(A copy of 'Summary of Your Rights Under the Fair Credit Reporting Act' is included with this authorization)

Printed Full Name of Applicant: ____

Other Names Used & Date Changed: ____
(Including maiden name) (Year changed)

Telephone Number/s: ____

Current Address: ____
(Mon/Year) (Street) (City) (State) (City)

Previous Address: ____
(Mon/Year) (Street) (City) (State) (City)

Previous Address: ____
(Mon/Year) (Street) (City) (State) (City)

Social Security # _________/_________/_________ Date of Birth: _______/_______/_______ (Month, Day, Year)

(If applicable) Driver's License # ___________________________________ State ___________________________

(If applicable) Professional License/s: _______________________________ State: ____________ Type: __________

Number: _________________

Have you ever been charged with or convicted of misdemeanor or felony crime? ______ Yes ______ No

If yes, please explain in some detail, including what county and state, and in what year:

____

____

I hereby authorize this employer and/or Global Safety Network and their agents, without any reservation, to investigate my background as it pertains to employment history and performances, personal and professional references, educational history, licenses and information contained in public records, including but not limited to credit, criminal, motor vehicle data and workers' compensation. I hereby release all persons, companies or other entities furnishing such information from liability and responsibility in connection herewith. I further authorize ongoing procurement of the types of reports mentioned herein at any time during my employment (or contract) with the company. A photocopy of this document may be substituted for the original.

Signature of Applicant: ____ Date: _________________________

MN/CA/OK Residents Only: Do you wish to receive a copy of your consumer report? ___ Yes ___ No

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

REGARDING BACKGROUND REPORTS FROM THE *PSP Online Service*

In connection with your application for employment with QFS Transportation, LLC (“Prospective Employer”), Prospective Employer, its independent contractors, 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 QFS Transportation, LLC (“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 independent contractor.

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 independent contractors, 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.

NOTICE: The prospective employment concept referenced in this form contemplates the definition of "independent contractor" contained at 49
C.F.R. 383.5.

LAST UPDATED 2/11/2016

Date: ______________________

TO: Drivers & Owner/Operators

FROM: Safety Department

SUBJECT: Worker Compensation Requirements

As your state of residence currently does not require any Workers' Compensation requirements, the company would like to re-affirm with you that the agreement signed between you, the "Contractor, and the "Company" denotes you as an Independent Contractor and not an independent contractor of the company, and any driver supplied by a Contractor will be an independent contractor of the Contractor. As such, you would not hold the "Company" responsible in the event of an occupational accident incurred by one or one of your drivers.

I, ____, know and understand the above statement concerning my status
(Print Driver Name)
as an independent contractor or as an employee of an independent contractor.

Driver Signature:____

Printed Name: ____

Date: ________________________________

Tractor #:____________________________

Atlantic Specialty Insurance Company

Canton, Massachusetts

DRIVER ENROLLMENT AND BENEFICIARY FORM

TRUCKERS OCCUPATIONAL ACCIDENT INSURANCE

QFS Transportation, LLC #216-002-047

Paid By: 1099 ☐ W-2 ☐

Please print:

Name: ______________________________ Male: ______ Female:______

Street Address: ______________________________ City: _________________ State: ______ Zip: ____________

Social Security Number: _________________ Date of Birth: _______________ E-Mail Address:_________________

Home Telephone Number: _____________________Cell Telephone Number: _____________________

Name of Beneficiary:_____________________________ Relationship of Beneficiary: _____________________

CDL or Required License Number:_____________________________ Number of Years Experience: ________

Contracted by (Name of Company): _____________________________ Effective Date of Contract: ________________

Street Address: ______________________________ City: _________________ State: ______ Zip: ____________

Motor Carrier Telephone Number: _____________________ Fax Number: _____________________

Motor Carrier E-Mail Address: ______________________________

FRAUD STATEMENT

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.

In providing this information, I, the undersigned, understand and hereby state that:

1. to the best of my knowledge and belief, all information on this Form is complete and truthful;
2. this coverage is not a contract for Statutory Workers' Compensation Insurance, and neither I nor my carrier become participants in the Workers' Compensation system by purchasing this insurance; and
3. if, based on the information supplied in this Form, I am not eligible for coverage, premium will be refunded and no claims will be payable.

By my signature below, I, the undersigned, also authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records, to furnish such information or copies of records to Atlantic Specialty Insurance Company, the motor carrier or the motor carrier's designee. A photographic copy of this authorization shall be as valid as the original.

IF THE INFORMATION PROVIDED IN THIS FORM IS FRAUDULENT,
THE INSURER HAS THE RIGHT TO RETURN PREMIUM AND CANCEL COVERAGE.

In order to verify the information provided in this Form, I, the undersigned, give the Insurer authority to examine the records that are maintained by the motor carrier.

I certify that I am an independent contractor, paid by a 1099 tax form, not as a W-2 employee.

Driver's Signature: ______________________________ Date: ____________________

Motor Carrier Representative's Signature: ______________________________

Payment Authorization: I authorize the above named motor carrier, with whom I have a contract, to take monthly deductions, equal to my premiums, from my settlement account on my behalf, and to remit these funds to Atlantic Specialty Insurance Company.

I UNDERSTAND THAT THE COST OF THE INSURANCE IS MY SOLE OBLIGATION AND RESPONSIBILITY, regardless of the above arrangement of premium payment. I agree that I will forward any amount due and owing to Atlantic Specialty Insurance Company, upon demand, for any insurance at any time my account remains unpaid.

Signature: ______________________________ Date:_____________________