



CONDITIONAL JOB OFFER & MEDICAL REVIEW

POSITION

DATE OF OFFER

Based on qualifications presented on your Employment Application Form, and/or, in your job interview, you are hereby offered a job with our organization conditional upon submitting to our standard medical review and the verification of your answers to the following questions. Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job [with accommodations if requested, or you present a hazard to yourself or others.

False or misleading statements are also grounds for rescinding this offer. This form must be accurate and complete to be processed. This information is considered personal, medical, and confidential in nature and will be treated as such by handling it confidentially in strict compliance with the American with Disabilities Act. This offer is only valid if signed by a company representative.

EMERGENCY INSTRUCTION	
Name	Phone Number
Relationship	
Address, City, State & Zip	
Are there any other emergency instructions, circumstances, medical needs, allergic responses, or procedures the company should know? Yes <input type="checkbox"/> No <input type="checkbox"/>	

HEALTH AND SAFETY			
HAVE YOU HAD AN INJURY OR INJURIES ON THE JOB? [If yes, complete information below] Yes <input type="checkbox"/> No <input type="checkbox"/>			
Date of Injury	Employer		
Body Part(s) Affected			
Amount of Loss Time	Any Permanent Disability?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, List Percent (%) of Permanent Disability Assigned to you During Medical Evaluation			
WAS A WORKERS' COMPENSATION CLAIM FILED? Yes <input type="checkbox"/> No <input type="checkbox"/>			
HAS THERE BEEN MORE THAN ONE INCIDENT OF INJURIES RECEIVED ON THE JOB? If yes, complete below Yes <input type="checkbox"/> No <input type="checkbox"/>			
Date of Injury	Employer		
Body Part(s) Affected			
Cause			
Amount of Loss Time	Any Permanent Disability?		% Yes <input type="checkbox"/> No <input type="checkbox"/>
WAS A WORKERS' COMPENSATION CLAIM FILED? Yes <input type="checkbox"/> No <input type="checkbox"/>			
HAVE YOU HAD ANY OTHER INJURIES OR ILLNESSES NOT RELATED TO PAST EMPLOYMENT [Home, Sports, Hunting, etc.] THAT HAVE RESULTED IN HOSPITALIZATION, SURGERY, OR LOST TIME? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Date of Injury	Body Part(s) Affected	Cause	
Days in the Hospital	Days in the Hospital	Days Lost-Work Time	
Have you Recovered? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Pursuant to compliance with 49 CFR Part 382.213; are you taking any long term medication [longer term= > 30 days] that will adversely affect the safe operation of a Commercial Motor Vehicle/Personal Vehicle or other company equipment? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please describe			
Type of Medication	Type of Medication		
Type of Medication	Type of Medication		
Any Side Effects the Company Should Be Aware Of?	Any Side Effects the Company Should Be Aware Of?		
Pursuant to compliance with 49 CFR Part 382.213; has the physician prescribing the long term medication advised the employee/applicant that substances/compounds found in the prescription will not adversely affect your ability to safely operate any type/class of Commercial Motor Vehicle, or personal vehicle, or equipment. Please provide documentation to that affect to H & H TRANSPORT, LLC.			Yes <input type="checkbox"/> No <input type="checkbox"/>



FMCSR ALCOHOL & CONTROLLED SUBSTANCE INFORMATION				
PER MANDATED REQUIREMENTS UNDER 49 CFR PART 40.25(j) APPLICANTS/EMPLOYEES ARE REQUIRED TO FURNISH THE FOLLOWING INFORMATION IN RELATION TO PRE-EMPLOYMENT CONTROLLED SUBSTANCE TESTING FOR THE PRECEDING THREE (3) YEARS.				
WERE YOU SUBJECT TO PRE-EMPLOYMENT CONTROLLED SUBSTANCE TESTING WITH ANY DOT AGENCY REGULATED EMPLOYER WITH WHOM YOU APPLIED FOR A POSITION PERFORMING DOT REGULATED "SAFETY SENSITIVE" FUNCTIONS, BUT <u>DID NOT</u> OBTAIN THE POSITION? YES <input type="checkbox"/> NO <input type="checkbox"/>				
LIST EMPLOYER, DATE OF TEST, TYPE OF TEST, TEST RESULT AND LOCATION OF TEST				
EMPLOYER NAME & ADDRESS	DATE OF TEST	TYPE OF TEST Random, Post Accident, etc.	LOCATION OF TEST Lab, Office, etc.	TESTS RESULTS
HAVE YOU HAD A PRE-EMPLOYMENT, VERIFIED POSITIVE, CONTROLLED SUBSTANCE TEST RESULT WITHIN THE LAST THREE YEARS?				YES <input type="checkbox"/> NO <input type="checkbox"/>
HAVE YOU "REFUSED-TO-SUBMIT" TO A PRE-EMPLOYMENT CONTROLLED SUBSTANCE TEST TO INCLUDE VERIFICATION OF SUBMITTING AN ADULTERATED and/or SUBSTITUTED TEST SPECIMEN WITHIN THE LAST THREE YEARS?				YES <input type="checkbox"/> NO <input type="checkbox"/>
IF YOU HAD A PRE-EMPLOYMENT CONTROLLED SUBSTANCE TEST THAT WAS VERIFIED POSITIVE OR CLASSIFIED AS "REFUSAL TO SUBMIT" WITHIN THE LAST THREE [3] YEARS, CAN YOU DOCUMENT SUCCESSFUL COMPLETION OF THE 'RETURN TO DUTY' PROCESS TO INCLUDE SAP EVALUATION, RETURN-TO-DUTY & FOLLOW-UP TEST RESULTS?				YES <input type="checkbox"/> N/A <input type="checkbox"/> NO <input type="checkbox"/>
COMMENTS				

AFFIRMATION AND AUTHORIZATION	
I HEREBY AFFIRM THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT, AND THAT THERE ARE NO OMISSIONS. I AUTHORIZE ANY PHYSICIAN, MEDICAL FACILITY, LAW ENFORCEMENT AGENCY, ADMINISTRATOR, STATE AGENCY, INSTITUTION, INFORMATION SERVICE BUREAU, INSURANCE COMPANY, OR PREVIOUS EMPLOYER CONTACTED BY THIS COMPANY, OR AN AGENT OF THIS COMPANY, TO FURNISH AND/OR VERIFY EMPLOYMENT INFORMATION, WORKERS' COMPENSATION INFORMATION AND/OR MEDICAL RECORDS AS REQUESTED.	
I FURTHER ACKNOWLEDGE THAT A TELEPHONE FACSIMILE (FAX) OR PHOTOGRAPHIC COPY SHALL BE AS VALID AS THE ORIGINAL.	
_____ SIGNATURE	_____ TODAY'S DATE
Upon successful completion of this review you will be given a start date	
_____ TODAY'S DATE	_____ AUTHORIZED SIGNATURE OF COMPANY REPRESENTATIVE
EMPLOYER USE ONLY VERIFICATION [HR and/or SAFETY DEPARTMENT]	



CERTIFICATE OF COMPLIANCE [DQF]

WITH DRIVER LICENSE REQUIREMENTS @ 49 CFR PART 383.21 &

H & H TRANSPORT, LLC shall comply with the requirements in 49 CFR PART 383 which applies to all drivers who will operate a Commercial Motor Vehicle with a GVWR/GCWR rating of 26,001 LB or more, in intrastate, interstate, or foreign commerce.

H & H TRANSPORT, LLC shall comply with the requirements in 49 CFR PART 391, which applies to all driver who operates a Commercial Motor Vehicle in interstate commerce, having a GVWR/GCWR rating or 10,001 pounds or more.

DRIVER REQUIREMENTS

49 CFR PART 383 & 391 of the Federal Motor Carrier Safety Regulations contain specific requirements, which you, as a driver for H & H TRANSPORT, LLC shall comply with. These requirements were placed into effect as of July 1, 1987. They are as follows:

1) **POSSESS ONLY ONE DRIVER LICENSE:** You, as a commercial vehicle driver, shall not possess more than one motor vehicle operator's license. [383.21(a)]

- If you have more than one driver license, maintain the applicable license from your state of residence. Return any additional driver licenses to the states that issued them.
- DESTROYING a driver 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 the record of the driver license 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:** Section 383.33 of the Federal Motor Carrier Safety Regulations mandate that you notify your employer the next business day of any type of revocation, suspension, or cancellation of your driver license.

3) **NOTIFICATION OF VIOLATION OF LOCAL, STATE, OR FEDERAL TRAFFIC REGULATIONS:**

- H & H TRANSPORT, LLC policy requires employees to notify their immediate supervisor in the event they receive a traffic citation, (other than a parking ticket), from local, State, or Federal authorities, either in a company vehicle or personal vehicle.
- Section 383.31 of the Federal Motor Carrier Safety Regulations mandates that any time you are convicted of a traffic citation, (other than a parking ticket), from local, State, or Federal authorities, you must **report** that conviction to your employer and the State that issued your license, within in 30 calendar days.

The driver license listed below is the only one I do, and shall possess

DATE	_____
DRIVER'S LICENSE NUMBER	_____
STATE	_____ EXPIRATION DATE _____
PRINT EMPLOYEE NAME	_____
EMPLOYEE SIGNATURE	_____



EMPLOYEE STATEMENT OF ON DUTY HOURS [DQF]
NEW/INTERMITTENT/CASUAL/OCCASIONAL DRIVERS [49 CFR PART 395.8(j)(2)1]

MANAGEMENT INSTRUCTION

When H & H TRANSPORT, LLC dispatches a driver for the first time, we shall obtain from the driver, a signed statement giving the total time "ON-DUTY" during the immediately preceding 7 days, and the time at which such driver was last relieved from duty **prior to** beginning work for H & H TRANSPORT, LLC [FMCSR 395.8(j)(2)].

This **shall include** any and all compensated work for any company during the preceding 7 days; **including** work for a non-motor carrier entity shall be recorded on this form.

DRIVER INSTRUCTION

When employed, new employees shall report all "ON-DUTY" time for the **preceding 7 days**, including time working for other employers, whether the employer is a motor carrier or non-motor carrier entity. The definition of "ON-DUTY" [FMCSR 395.2(8-9)] time includes any compensated time performing any other work in the capacity of, or in the employ or service of any other employer.

NAME OF DRIVER (PRINT)	SOCIAL SECURITY NUMBER	DATE OF EMPLOYMENT
DRIVER'S LICENSE NUMBER	CLASS OF LICENSE & ISSUING STATE	EXPIRATION DATE

DAY	1 YESTERDAY	2	3	4	5	6	7	
DATE								
HOURS WORKED								TOTAL "ON DUTY" HOURS

ARE YOU CURRENTLY WORKING ANOTHER EMPLOYER?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
DO YOU INTEND TO WORK FOR ANOTHER EMPLOYER WHILE STILL EMPLOYED BY THIS COMPANY?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

EMPLOYEE/DRIVER CERTIFICATION	
I HEREBY CERTIFY THAT THE INFORMATION GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.	
I WAS LAST RELIEVED FROM WORK AT:	
TIME _____ AM <input type="checkbox"/> PM <input type="checkbox"/>	ON (DD/MM/YY) _____
DRIVER'S SIGNATURE: _____	DATE _____

EMPLOYMENT CHECKLIST FOR INTERMITTENT, CASUAL OR OCCASIONAL DRIVER

The Driver Qualification File for an intermittent, casual, or casual driver employed under the rules in Section 391.63 shall include the following forms per Section 391.51(d) and shall be retained by each facility for a period of 3 years.

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| MEDICAL EXAMINER CERTIFICATE [391.43]
Physical qualifications to operate commercial motor vehicle or legible photographic copy of the certificate | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| CERTIFICATE OF ROAD TEST [391.31(E)]
Certificate of driver's road test issued to the driver, or a copy of the license and/or certificate which H & H TRANSPORT, LLC accepted as equivalent to the "CERTIFICATE OF ROAD TEST" | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| VERIFY the employee/driver is currently subject to alcohol/controlled substance testing programs as required by Section 382 of the FMCSR. Ensure completion of verification prior to use as a commercial motor vehicle driver | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|



EQUIVALENT OF ROAD TEST

Drivers Name _____

Address _____

License Number _____ State _____

1. Pursuant to 49 CFR PART 391.33, H & H TRANSPORT, LLC may, at its discretion, accept a valid Commercial Driver's License as defined in 49 CFR PART 383.5, not to include Double/Triple Trailer or Tank Vehicle Endorsement, which has been issued to the applicant/employee to operate specific categories of Commercial Motor Vehicles and which, under the laws of that State, license the applicant/employee after the successful completion of a road test in a comparable Commercial Motor Vehicle that the applicant/employee will be assigned to perform his/her assigned duties during employment with H & H TRANSPORT, LLC, or
2. Accept a copy of a valid CERTIFICATION OF ROAD TEST issued to the applicant/employee within the preceding three (3) years.

If H & H TRANSPORT, LLC accepts either of the ABOVE two (2) exceptions for a completed Road Test, a copy of the License and/or CERTIFICATION OF ROAD TEST shall be maintained in the applicant/employee DRIVER QUALIFICATION FILE.



AUTHORIZATION FOR MEDICAL RECORDS & COMMUNICATIONS RELEASE

Employee Name _____

Address _____

Date _____ Time _____ AM PM

I, (PRINT NAME LEGIBLY) _____

authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic, or other medical related facility, insurance company or other organization; institution or person that has any records or knowledge of my physical or mental health history, and/ or condition of well-being, to supply such information to my employer, H & H TRANSPORT, LLC its insurers, Claims Administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally, or in writing, with my employer, H & H TRANSPORT, LLC its insurers, Claims Administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment, and as to any other issues including FMCSA-DOT Physicals, physical capacity tests, diagnosis, prognosis, casual connection of care and treatment to any work related injury or work related duties and my ability to perform those assigned duties.

In conjunction with this authorization I also authorize any treating physician or medical provider to review any additional medical materials provided to them.

A photocopy of this authorization shall be as valid as the original. This authorization shall remain valid for the length/term of my employment with H & H TRANSPORT, LLC

PRINT NAME LEGIBLY _____

EMPLOYEE SIGNATURE _____

WITNESS _____



**DESIGNATED MEDICAL PROVIDER
EMPLOYEE ACKNOWLEDGMENT FORM**

In the event H & H TRANSPORT, LLC employee should receive an injury during the performance of assigned duties, the employee shall obtain treatment for that injury at the Designated Medical Provider for this company.

H & H TRANSPORT, LLC DESIGNATED MEDICAL PROVIDERS are:

Clinic Name: _____ Clinic Name: _____
Address1: _____ Address 1: _____
Address2: _____ Address2: _____
Phone: _____ Phone: _____

Clinic Name: _____ Clinic Name: _____
Address1: _____ Address 1: _____
Address2: _____ Address2: _____
Phone: _____ Phone: _____

In the event of a life or limb threatening emergency, the injured employee shall be sent to the nearest emergency medical facility for immediate treatment. Follow up care shall be provided by the Designated Medical Provider for the particular project that the employee is assigned to.

Employees who receive treatment for work related injuries at a clinic other than the Designated Medical Provider for this company the employee shall be responsible for payment of any applicable charges.

Employees who receive treatment for Non-work related injuries at the Designated Medical Provider shall be responsible for the payment of that care either through an out of pocket expenses, and/or applicable personal health insurance benefits.

In addition, H & H TRANSPORT, LLC employees, per mandated State Regulations, are subject to a potential 50% reduction of Monetary Workers' Compensation benefits when found to be under the influence of alcohol and/or controlled substances when injured during the performance of their assigned duties.

In addition, H & H TRANSPORT, LLC employees, per mandated State Regulations, are subject to a potential of Monetary Workers' Compensation benefits for failure to comply with applicable safety policies/procedures, and/or utilize applicable Personal Protective Equipment.

Where an employee and/or applicant willfully misleads H & H TRANSPORT, LLC concerning the employee/applicant's ability to perform the physical functions of a position, and the employee/applicant is subsequently injured on the job as a result of the physical limitations Workers' Compensation monetary and medical benefits may be denied by State regulations.

I acknowledge that I have been informed of the policy regarding the use of Designated Medical Provider.

I also acknowledge that I have been informed of the mandated State Regulations regarding the potential reduction of Monetary Workers' Compensation benefits for failure to comply with H & H TRANSPORT, LLC safety polices/procedures, utilizing applicable Personal Protective Equipment, and use of alcohol and/or controlled substances that maybe a contributing factor to an injury during the performance of my assigned duties.

I have been informed on how I may gain additional information regarding this information.

I accept the policies and procedures as working document that I shall support during my daily performance of assigned duties. I acknowledge compliance with this program as a condition of employment with H & H TRANSPORT, LLC.

DATE _____ TIME _____ AM PM

PRINT EMPLOYEE NAME _____

EMPLOYEE SIGNATURE _____



REQUEST FOR INFORMATION FROM PREVIOUS EMPLOYER

[49 CFR PART 40.25 & 391.23(a)(2)]

SECTION 1: TO BE FILLED OUT BY PROSPECTIVE EMPLOYEE

I, [PRINT NAME] _____, hereby authorize the release of the following information regarding my previous employment and "Safety Performance History" with the company listed below. Please provide the following information to include:

1. Verification of general driver identification including my name & Employee Identification and/or Social Security number; and
2. Whether or not I was involved in any Commercial Motor Vehicle Accident as defined in Federal Motor Carrier Safety Regulations, 49 CFR PART 390.5 "ACCIDENT", and
3. If involved in an "ACCIDENT", as defined in FMCSR 49 CFR PART 390.5, the specific information regarding this "ACCIDENT" as required by 49 CFR PART 390.15(b)(1), and
4. When/where applicable, if my assigned duties included the performance of Safety-Sensitive Functions that required Alcohol and/or Controlled Substance [drug] testing specified un 49 CFR PART 40 with test results that, and whether or not I had any test results that meet the following criteria to include:
 - a. Alcohol test with a result of 0.04 or higher; and/or
 - b. Verified positive controlled substance [drug] test result; and/or
 - c. Any "REFUSALS" to be tested and/or completion of the Alcohol and/or Controlled Substance [drug] Testing Process; and/or
 - d. Other violations of DOT agency Alcohol and/or Controlled Substance [drug] regulations; and/or
 - e. Information obtained from other previous employers of an Alcohol and/or Controlled Substance [drug] rule violation; and/or
 - f. When/where applicable. documentation of completion of the "RETURN-TO-DUTY" process following a Alcohol and/or Controlled Substance [drug] rule violations; and/or

SECTION 2: PREVIOUS EMPLOYER INFORMATION

Previous Employer: _____
 Complete Address: _____
 City, State, Zip: _____
 Telephone: _____ FAX: _____

H & H TRANSPORT, LLC
 ATTENTION: HUMAN RESOURCES
 Address1
 Address2
 PHONE: Phone

 APPLICANT SIGNATURE DATE

NOTE TO PREVIOUS EMPLOYER

This request is in compliance with 49 CFR Parts 391.23 & 40.25, which states:
 As an employer, H & H TRANSPORT, LLC must, after obtaining the applicant/employee's written consent, request information regarding this applicant/employee's previous employment information to include "Safety Performance History" & previous Alcohol and/or Controlled Substance Testing Results for the **previous three (3) years**, from the date of the applicant/employees application, and/or transfer to a position that requires the performance "Safety-Sensitive Duties".

This request is being made to all dot-regulated agency employers this applicant listed on his/her employment application.
 Please provide the requested information, to include information received from other previous Dot-Regulated Agency Employers to the H & H TRANSPORT, LLC at the address and/or phone/fax number listed above. Thank you for your time and cooperation in this matter!



SECTION 3: TO BE COMPLETED BY PREVIOUS EMPLOYER

NAME OF APPLICANT: _____

SOCIAL SECURITY/EMPLOYEE IDENTIFICATION NUMBER: _____

EMPLOYED FROM: _____ TO: _____

DID APPLICANT/EMPLOYEE PERFORM ASSIGNED DUTIES THAT INVOLVED THE PERFORMANCE OF "SAFETY-SENSITIVE" and/or "COVERED" FUNCTIONS IN RELATION TO TRANSPORTATION OR OTHER DOT-AGENCY REGULATED ASSIGNMENTS? YES [] NO []

UNDER 49 CFR PART 40.25 GUIDELINES PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING PREVIOUS DRUG & ALCOHOL TESTING:

1. HAS THIS APPLICANT EVER HAD A VERIFIED ALCOHOL TEST WITH A BREATH ALCOHOL CONCENTRATION TEST RESULT GREATER THAN 0.04 GRAMS OF ALCOHOL/210 LITERS OF BREATH IN THE LAST THREE YEARS? YES [] NO []
2. HAS THIS APPLICANT EVER HAD A MRO VERIFIED POSITIVE CONTROLLED SUBSTANCE [drug] TEST RESULT IN THE LAST THREE YEARS? YES [] NO []
3. HAS THIS APPLICANT EVER "**REFUSED TO SUBMIT**" TO AN ALCOHOL and/or CONTROLLED SUBSTANCE TEST IN THE LAST THREE YEARS, AS DEFINED IN 49 CFR PART 382.107, "REFUSE TO SUBMIT" TO AN ALCOHOL OR CONTROLLED SUBSTANCE TEST" ITEMS 1-9? THIS DEFINITION INCLUDES A MRO VERIFIED "ADULTERATED" and/or "SUBSTITUTED" TEST SPECIMEN. YES [] NO []

NOTE: DOT-AGENCY, AS DEFINED IN 49 CFR PART 382.107 INCLUDES THE FOLLOWING AGENCIES:

- These terms encompass all DOT regulated agencies, including, but not limited to:
 - ❖ FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION [FMCSA]
 - ❖ FEDERAL RAILROAD ADMINISTRATION [FRA]
 - ❖ FEDERAL AVIATION ADMINISTRATION [FAA]
 - ❖ NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION [NHTSA]
 - ❖ PIPELINE & HAZARDOUS MATERIALS SAFETY ADMINISTRATION [PHMSA]
- 4. DOES THIS APPLICANT HAVE ANY OTHER VIOLATIONS OF ANY DOT-AGENCY ALCOHOL and/or CONTROLLED SUBSTANCE [drug] TESTING REGULATIONS THAT YOU ARE AWARE OF OR HAS BEEN REPORTED TO YOU BY A PREVIOUS EMPLOYER? YES [] NO []
- 5. IS THERE ANY INFORMATION FROM PREVIOUS EMPLOYERS OF A VERIFIED POSITIVE ALCOHOL and/or CONTROLLED SUBSTANCE [drug] TEST RESULT IN THE LAST THREE YEARS? YES [] NO []

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, DID THE APPLICANT SUCCESSFULLY COMPLETE THE RETURN-TO-DUTY PROCESS TO INCLUDE:

1. FACE-TO-FACE EVALUATION & CLINICAL ASSESSMENT BY A SUBSTANCE ABUSE PROFESSIONAL? YES [] NO []
2. "RETURN-TO-DUTY" ALCOHOL and/or CONTROLLED SUBSTANCE TEST WITH NEGATIVE TEST RESULTS? YES [] NO []
3. MINIMUM OF SIX (6) "FOLLOW-UP" ALCOHOL and/or CONTROLLED SUBSTANCE TEST WITH ALL HAVING NEGATIVE TEST RESULTS? YES [] NO []
4. POST TREATMENT EVALUATION BY A SUBSTANCE ABUSE PROFESSIONAL [SAP]? YES [] NO []

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE THE FOLLOWING MANDATED DOCUMENTATION OF THE FOLLOWING RETURN-TO-DUTY PROCESS. THIS WILL INCLUDE:

1. COPY OF SAP EVALUATION FOR EACH OCCURRENCE YES [] NO []
2. COPY OF THE NEGATIVE RETURN-TO-DUTY TEST RESULT YES [] NO []
3. COPIES OF THE FOLLOW-UP TESTS RESULT YES [] NO []
4. COPY OF THE POST TREATMENT EVALUATION BY THE SAP YES [] NO []
5. NAME/ADDRESS/PHONE NUMBER OF THE SAP YES [] NO []

NAME OF SAP: _____

ADDRESS: _____

PHONE NUMBER: _____ DATE OF TREATMENT: _____



UNDER 49 CFR PART 391.23(d), PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING PAST DRIVING/SAFETY PERFORMANCE OF THIS APPLICANT/EMPLOYEE:

1. PLEASE VERIFY THE IDENTIFICATION OF THIS APPLICANT BY CONFIRMING HIS/HER EMPLOYEE IDENTIFICATION and/or SOCIAL SECURITY NUMBER. _____
2. CHECK THE TYPE OF EQUIPMENT THE APPLICANT/EMPLOYEE OPERATED DURING HIS/HER EMPLOYMENT WITH YOUR COMPANY FOR THE PAST THREE YEARS:
 - STRAIGHT TRUCK WITH GVWR GREATER THAN 10,001 LB? YES [] NO []
 - STRAIGHT TRUCK WITH GVWR GREATER THAN 26,001 LB? YES [] NO []
 - COMBINATION TRUCK & TRAILER WITH GCWR GREATER THAN 26,001 LB? YES [] NO []
 - COMBINATION TRUCK & TRAILER WITH GCWR GREATER THAN 52,000 LB? YES [] NO []
3. WAS THE APPLICANT/EMPLOYEE INVOLVED IN ANY TYPE OF COMMERCIAL MOTOR VEHICLE ACCIDENT THAT REQUIRED ANY VEHICLE(S) TO BE TOWED AWAY FROM THE SCENE OF THE ACCIDENT? YES [] NO []

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE THE FOLLOWING MANDATED [49 CFR PART 391.23(d)(2)] INFORMATION:

4. DATE OF THE ACCIDENT(S): _____
5. LOCATION OF THE ACCIDENT TO INCLUDE CITY, OR NEAREST TOWN & STATE: _____
6. LIST NUMBER OF INJURIES RELATED TO THIS ACCIDENT(S) TO INCLUDE INJURY TO EMPLOYEE/DRIVER: _____
7. WAS THERE ANY FATALITIES RELATED TO THIS ACCIDENT? YES [] NO []
8. IF SO, PLEASE LIST NUMBER OF FATALITIES RELATED TO THIS ACCIDENT, INCLUDING EMPLOYEES/DRIVERS. _____
9. WAS THERE ANY HAZARDOUS MATERIALS INCIDENTS, OTHER THAN FUEL SPILLED FROM VEHICLE TANKS, RELATED TO THIS ACCIDENT/INCIDENT? YES [] NO []
10. PLEASE PROVIDE A PERFORMANCE RATING FOR THIS APPLICANT/EMPLOYEE BASED ON ATTITUDE, ATTENDANCE AND SAFETY PERFORMANCE.
 - ABOVE AVERAGE [] AVERAGE [] BELOW AVERAGE []

PREVIOUS EMPLOYER'S ADDITIONAL COMMENTS:

SECTION 2 COMPLETED BY (SIGNATURE): _____ DATE: _____
 TITLE: _____

ADDRESS: _____
 PHONE: _____ FAX: _____

SECTION 4: TO BE COMPLETED BY HUMAN RESOURCES and/or SAFETY DEPARTMENT:

THIS FORM WAS (CHECK ONE) FAXED/MAILED TO PREVIOUS EMPLOYER FAXED: [] MAILED: [] DATE _____

SECOND REQUEST WAS SENT TO THIS PREVIOUS EMPLOYER BY FAX: [] MAIL: [] DATE: _____

COMPLETE INFORMATION BELOW WHEN REQUESTED INFORMATION IS OBTAINED

INFORMATION RECEIVED FROM: _____

METHOD RECORDED BY: FAX [] MAIL [] PHONE [] PERSONAL INTERVIEW []

SIGNATURE/DATE OF PERSON COMPLETING SECTION: _____ DATE: _____



Title: Truck Driver Responsibilities

Name: _____

Date: _____

Immediate Supervisor: Operations Manager/Dispatcher

GENERAL SUMMARY: Truck drivers are expected to perform their assigned duties in a safe, responsible & professional manner, to include the correct completion of all the paperwork [Log books, Driver Vehicle Inspection Reports, Time Cards, etc.] that is associated with the operation of a Commercial Motor Vehicle in commerce.

In addition each driver is required to turn in all paperwork associated with the load, including:

- ➔ Bill of Lading/Shipping Manifest/Load Sheets, and
- ➔ Driver Vehicle Inspection Reports, and
- ➔ Log Books, and/or
- ➔ Time Cards, and/or
- ➔ All Colorado Motor Carrier Driver Vehicle Inspection Reports, and
- ➔ Other State Motor Carrier Driver/Vehicle Inspection Reports, and/or
- ➔ Overweight Tickets, and/or
- ➔ Traffic Citations, and/or
- ➔ Supporting documentation of the load/trip such as:
 - ❖ Fuel Receipts
 - ❖ Lodging Receipts;
 - ❖ Meal Receipts
 - ❖ Toll Road Receipts; and
 - ❖ All other supporting documentation you may receive in the course of transporting and delivery of your load.

In addition, where applicable, Daily Vehicle Inspection Reports need to have applicable signatures in the appropriate area of the Report Form depending on, if there was a defect noted and/or repaired on truck.

All logs and reports need addresses, signatures, mileage, truck numbers, and all other info it asks for.

Leased drivers will be required to provide H & H TRANSPORT, LLC copies of all paperwork associated with the maintenance of their vehicles to include:

- ➔ Annual Vehicle Inspection Reports, for each power unit and/or trailer owned/utilized by the leased driver; and
- ➔ Tire Size for power unit and/or all trailers; and
- ➔ Maintenance Schedule [Oil changes, lubrication, tire rotation, etc.]; and
- ➔ All vehicle/trailer repairs listed on the Vehicle Inspection Reports and/or completed as part of maintenance; and
- ➔ Tire replacement; etc.
- ➔ Copies of receipts and/or work orders for repairs.

These are not unusual requirements and are the responsibilities of all professional drivers. If you are going to drive for H & H TRANSPORT, LLC you are required to be a well-informed professional driver who understands the importance of these responsibilities.

Non-compliance with these responsibilities is not acceptable and appropriate disciplinary and/or other actions will be undertaken for those drivers who fail to complete these defined responsibilities.

SIGNATURE: Employee: _____ Date: _____

SIGNATURE: Leased/Company Driver: _____ Date: _____

Supervisor Signature: _____



BRAKE INSPECTOR QUALIFICATIONS STATEMENT
PERIODIC BRAKE INSPECTIONS & MAINTENANCE [49 CFR PART 396.25]

I, [Print Name] _____, hereby certify that I understand the brake inspector qualification & regulations. I am qualified to perform the CMV vehicle brake inspections, maintenance, service and repairs under 49 CFR PART 396.25(d) or (e) as follows:

1. I understand the inspection criteria set forth in 49 CFR PART 393 & APPENDIX G to SUBCHAPTER B [49 CFR] - MINIMUM PERIODIC INSPECTION STANDARDS.
2. I am knowledgeable of and have mastered the methods, procedures, tools, and equipment used when perform and inspection, and
3. I am capable of performing an inspection by reason of experience, training or both as follows:

_____ I have a combination of training and/or experience totaling at least one year. Such training and/or experience consisted of:

- A. _____ I have successfully completed a State or Federal sponsored training program or have a certificate from a State or Canadian Providence which qualifies me to perform Commercial Motor Vehicle Safety Inspections, or
- B. _____ I have a total of _____ years of experience performing brake maintenance and/or inspections in several motor carrier maintenance programs, and/or commercial garage, and/or fleet leasing company or similar facility
- C. _____ I participated in a truck manufacture sponsored training program or similar Commercial Motor Vehicle training program [ATA] designed to train students in truck operations & maintenance.

PRINT INSPECTOR NAME: _____

INSPECTOR SIGNATURE: _____

I, herby certify that the above listed Employee/Inspector has met the requirement for a qualified inspector to perform the assigned tasks of Periodic Maintenance & Safety Procedures in compliance with the regulations of the US Depart OF Transportation for qualified Periodic & Annual Inspector, as contained in 49 CFR PART 396.16 & PART 396.23

PRINT EMPLOYER NAME: _____

SIGNATURE OF CMV OWNER: _____



CERTIFICATION OF INSPECTOR QUALIFICATIONS
PERIODIC & ANNUAL INSPECTIONS [49 CFR PART 396.19(b)]

I, _____, hereby certify that I understand the inspector qualification regulations in the performance of Periodic & Annual Inspections under 49 CFR Parts 393, 396.17, Part 396.23 and Appendix G of the Federal Motor Carrier Safety Regulations. I am qualified to perform the ANNUAL VEHICLE INSPECTION under 49 CFR PART 396.17(d) or (e) as follows:

1. I understand the inspection criteria set forth in 49 CFR PART 393 & APPENDIX G to SUBCHAPTER B [49 CFR] - MINIMUM PERIODIC INSPECTION STANDARDS.
2. I am knowledgeable of and have mastered the methods, procedures, tools, and equipment used when perform and inspection; and
3. I am capable of performing an inspection by reason of experience, training or both, as follows below:

_____ I have a combination of training and/or experience totaling at least one year. Such training and/or experience consisted of [Check all that apply & list years of experience]:

- A. _____ I have successfully completed a State or Federal sponsored training program or have a certificate from a State or Canadian Providence which qualifies me to perform Commercial Motor Vehicle Safety Inspections, or
- B. _____ I have a total of _____ years of experience as a mechanic or inspector in a motor carrier maintenance program.
- C. _____ I participated in a truck manufacture sponsored training program or similar Commercial Motor Vehicle training program designed to train students in truck operations & maintenance.

PRINT INSPECTOR [EMPLOYEE] NAME: _____

INSPECTOR [EMPLOYEE] SIGNATURE: _____

I, herby certify that the above listed Employee/Inspector has met the requirement for a qualified inspector to perform the assigned tasks of Periodic Maintenance & Safety Procedures in compliance with the regulations of the US Depart of Transportation for qualified Periodic & Annual Inspector, as contained in 49 CFR PART 396.16 & PART 396.23

MOTOR CARRIER NAME: _____

SIGNATURE OF MOTOR CARRIER OWNER or SUPERVISOR:
