



**SCHMIDT
& SONS, INC.**

P.O. Box 232
Gonzales, TX 78629
(830) 672-2018
Fax: (830) 672-7373

APPLICATION FOR EMPLOYMENT

SSN: _____

PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS – (Do not type – print in black ink)

Level of Experience _____ Referred By _____

THIS APPLICATION WILL BE CONSIDERED FOR (30) DAYS FROM THIS DATE. AFTER THAT TIME, THE APPLICATION MUST BE RENEWED TO BE CONSIDERED.

An individual is not permitted to drive a motor vehicle by the Department of Transportation unless he/she is physically qualified to do so. If prior to a conditional offer of employment, you are uncertain as to whether or not you are capable of passing the DOT physical or have questions about the requirements, you may submit your application and, if contacted about employment, request additional information from our personnel. A conditional offer of employment may be made, thereafter; you will be required to answer some medical questions. You may still be sent for a physical examination. Any information provided to our company is strictly confidential and will be used only for the purposes allowed by the Department of Transportation.

| | | | |
|---|--------------|--|---|
| <u>Last Name</u> | <u>First</u> | <u>Middle</u> | <u>Date</u> |
| <u>Have you ever been known by any other name? If yes give name.</u> | | | <u>Best time to reach you by phone.</u> |
| <u>Present street address</u> | | | <u>Phone</u> () |
| <u>City</u> | <u>State</u> | <u>Zip</u> | <u>Phone</u> () |
| <u>Permanent Address</u> | | | |
| <u>Residence for past 3 years</u> | | | |
| <u>Date of Birth:</u> | | <u>Social Security Number:</u> | |
| How did you hear about our company? (Circle all that apply) Radio TV Billboard Newspaper Magazine Other: List All - | | Do you have the legal right to work in the US? If hired, proof of status will be required. () YES () NO | |
| List any driving schools: Name, Phone Number, Location, and Graduation Date | | Circle Highest Grade Completed: 1 2 3 4 5 6 7 8 High School 1 2 3 4 College 1 2 3 4 Post-Grad | |
| MILITARY BRANCH | Dates: From | To | Highest Rank Achieved |
| | | | Rank at Discharge |
| Emergency Contact Name: | | Relation | Phone |
| | | | Address |
| Reference Name: | Occupation: | Phone: | Reference Name: |
| | | | Occupation: |
| | | | Phone: |

Circle Yes or No:

- A. Has any license, permit or privilege ever been revoked? Yes No
- B. Have you ever been arrested/convicted for driving under the influence of drugs or alcohol or have a current charge pending? Yes No
- C. Have you ever been arrested/convicted for possession, sale or use of a narcotic drug? Yes No
Amphetamine, or derivative thereof or have a current charge pending?
- D. Have you ever been convicted of a crime or have a current charge pending? Yes No
- E. Have you ever been convicted of an offense involving the use of drugs or alcohol? Yes No
- F. Have you ever tested positive on any drug test, tested at a breath alcohol concentration level of 0.02% Or greater on a breath alcohol test, or refused to take a drug or alcohol test when you were required to do so In accordance with any Federal regulation or a previous/current employer's policy? Yes No

If answer to either A, B, C, D, E, or F is yes, you must state the circumstances and date: _____

LIST ALL DRIVER'S LICENSES EVER HELD

SSN: _____

| STATE | LICENSE NUMBER | TYPE | DATES SURRENDERED | EXPIRATION DATE | CURRENT STATUS |
|------------------|----------------|------|-------------------|-----------------|----------------|
| Current License: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Do you possess a Commercial Driver's License (CDL) _____ Which endorsements do you have, If any? _____

TRAFFIC CONVICTIONS AND FORFEITURES

LIST ALL TRAFFIC CONVICTIONS, FORFEITURES OR SUSPENSIONS OF LICENSE IN A MOTOR VEHICLE (other than parking violations) FOR THE PAST 5 YEARS (IF NONE, WRITE NONE)

| DATE | TYPE OF VEHICLE | LOCATION (STATE) | CHARGE | PENALTY |
|------|-----------------|------------------|--------|---------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

ACCIDENT RECORD

LIST ALL ACCIDENTS YOU HAVE BEEN INVOLVED IN WHILE OPERATING A TRUCK, CAR, MOTORCYCLE, OR OTHER MOTORIZED VEHICLE INCLUDING PROPERTY DAMAGE, IN THE PAST 5 YEARS. INCLUDE ALL ACCIDENTS WHETHER AT FAULT OR NOT AT FAULT. (IF NONE, WRITE NONE)

| DATE | VEHICLE TYPE | NATURE OF ACCIDENT (Head on, Rear -end, upset, inc.) | WERE YOU AT FAULT | WERE YOU TICKETED | FATALITIES | INJURIES? | AMOUNT OF PROPERTY DAMAGE |
|------|--------------|--|----------------------|----------------------|------------|-----------|---------------------------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

EMPLOYMENT RECORD

FOR THE PAST 5 YEARS (10 COMMERCIAL DRIVING)

Begin with your present or most recent job and work backwards in order, listing all employers for at least 5 years (10 years of commercial driving) including all full time and part-time employment. All time must be accounted for including military service, school, self-employment and periods of unemployment. Use supplemental sheet if necessary for more than five employers. **We must have telephone numbers for all employers' reference.**

If unemployed: FROM _____ TO _____ DID YOU RECEIVE UNEMPLOYMENT BENEFITS? () YES () NO

Have you ever been discharged from a job? If so, please explain: _____

CURRENT EMPLOYER:

| DATES: FROM: TO: | COMPANY NAME | SUPERVISORS NAME | PHONE NUMBER | POSITION HELD & PAY RATE |
|---------------------|--------------|------------------|--------------|--------------------------------|
| | | | | |

ADDRESS: _____

List months of experience with each type of equipment: () straight truck () tractor & semi trailer () tractor & twin trailer
() tractor & flat bed () tractor & tanker () other

Why do you want to change employers? _____

Number of states driven in: _____ COMMENTS: _____

EMPLOYMENT RECORD CONTINUED

SSN: _____

If unemployed: FROM _____ TO _____ DID YOU RECEIVE UNEMPLOYMENT BENEFITS? () YES () NO

Have you ever been discharged from a job? If so, please explain: _____

SECOND LAST EMPLOYER:

| DATES: FROM: TO: | COMPANY NAME | SUPERVISORS NAME | PHONE NUMBER | POSITION HELD & PAY RATE |
|---------------------|--------------|------------------|--------------|--------------------------------|
| | | | | |
| ADDRESS: | | | | |

List months of experience with each type of equipment: () straight truck () tractor & semi trailer () tractor & twin trailer
() tractor & flat bed () tractor & tanker () other

Reason for Leaving ? _____

Number of states driven in: _____ COMMENTS: _____

If unemployed: FROM _____ TO _____ DID YOU RECEIVE UNEMPLOYMENT BENEFITS? () YES () NO

Have you ever been discharged from a job? If so, please explain: _____

THIRD LAST EMPLOYER:

| DATES: FROM: TO: | COMPANY NAME | SUPERVISORS NAME | PHONE NUMBER | POSITION HELD & PAY RATE |
|---------------------|--------------|------------------|--------------|--------------------------------|
| | | | | |
| ADDRESS: | | | | |

List months of experience with each type of equipment: () straight truck () tractor & semi trailer () tractor & twin trailer
() tractor & flat bed () tractor & tanker () other

Reason for Leaving ? _____

Number of states driven in: _____ COMMENTS: _____

If unemployed: FROM _____ TO _____ DID YOU RECEIVE UNEMPLOYMENT BENEFITS? () YES () NO

Have you ever been discharged from a job? If so, please explain: _____

FOURTH LAST EMPLOYER:

| DATES: FROM: TO: | COMPANY NAME | SUPERVISORS NAME | PHONE NUMBER | POSITION HELD & PAY RATE |
|---------------------|--------------|------------------|--------------|--------------------------------|
| | | | | |
| ADDRESS: | | | | |

List months of experience with each type of equipment: () straight truck () tractor & semi trailer () tractor & twin trailer
() tractor & flat bed () tractor & tanker () other

Reason for Leaving ? _____

Number of states driven in: _____ COMMENTS: _____
SSN: _____

TO BE READ AND SIGNED BY APPLICANT

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

DATE

APPLICANT'S PRINTED NAME

APPLICANT'S SSN:

APPLICANT'S SIGNATURE

DRIVER INSURABILITY REQUEST FORM

Account #: _____

Account Name: _____

| | |
|--------------------------|--------------|
| Date | No. of Pages |
| To Driver Insurability | From |
| Co Federated Insurance | Co |
| Phone No. 1-800-335-4687 | Phone No. |
| Fax No. | Fax No. |

Please call us at 1-800-335-4687 to use our Driver Insurability Service. You will be informed if the person is insurable to drive vehicles. Federated cannot provide you a copy of the MVR but see reverse side for important information which includes MVR options.

| | | | | |
|---|--|----------------|--------------------------|--------------------------------|
| <input type="checkbox"/> Prospective Employee. | <input type="checkbox"/> Employee | | | |
| Last | First | Middle Initial | Date of Birth | State of License |
| Driver's License Number | | | | Relationship to Named Insured* |
| | | | | 1 2 3 4 5 6 |
| CHECK THE APPROPRIATE BOX FOR EACH QUESTION: | | | | |
| | | | Yes | No |
| Have you ever been denied a driver's license or had one suspended or revoked? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any violations in the past 3 years? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any auto accidents in the past 3 years? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| IF THE ANSWER TO ANY QUESTION WAS "YES", please explain (give dates of violations and/or accidents) _____ | | | | |
| | | | | |
| DRIVER - I affirm that the statements made above are stated truthfully and without reservation. | | | | |
| Signed this _____ day of _____, _____ Driver's Signature _____ | | | | |

- * Please show Relationship to Named Insured, as indicated below, by circling the corresponding number above.
- | | |
|--|--|
| 1. Owner (owner, partner, officer, director) | 4. Driver or salesperson |
| 2. Owner's family member (spouse, dependent) | 5. All other-frequent use (not shown in 1 - 4 but often drives) |
| 3. Heavy truck driver (2 ton trucks and heavier) | 6. All other-infrequent use (not shown in 1 - 4 but rarely drives) |

OFFICE USE ONLY - TO BE COMPLETED BY FEDERATED

Insurable for driving vehicles

Exceeds standards/uninsurable for driving vehicles

Probationary - any more convictions or at-fault accidents change this driver to exceeds standards/uninsurable.

No MVR found based on information provided. Please revise incorrect data and return to Federated if still desired.

Comments

MVR Reviewer Name CST/Dept Date

| | |
|--------------------------|--------------|
| Date | No. of Pages |
| To Driver Insurability | From |
| Co Federated Insurance | Co |
| Phone No. 1-800-335-4687 | Phone No. |
| Fax No. | Fax No. |

IMPORTANT INFORMATION

You may request our Driver Insurability Service on new, prospective and existing employees whose jobs require driving. We will inform you if the driver is insurable to drive vehicles. Note: For each request for Alaska, Arkansas or Canada (except New Brunswick and New Foundland), include completed Motor Vehicle Authorization Form (WF-194).

You as the employer may order MVRs direct from Insurance Information Exchange (iiX). Please inform iiX that you want employment MVRs and are associated with Federated Insurance (so that you receive a preferred rate). Federated will not reimburse you for the cost of MVRs. **Call 800-683-8553 menu option 1.**

A driver who has been classified as exceeds standards/uninsurable or probationary may obtain a free copy of his/her MVR from iiX if the driver believes the MVR information is incorrect. It may take up to 30 days to receive the MVR. Only the driver may request his/her own free copy. **Call 800-683-8553 menu option 8.**

MVRs are available from local law enforcement centers, state department of motor vehicles, Insurance Information Exchange (iiX) or other MVR vendors. It is your responsibility as an employer to maintain appropriate records.

There is no charge to you for our service if used for drivers. If you use our service for non-driving positions, your policy premium may reflect an extra charge to offset our expenses. There are legal concerns with an employer's use of MVR information with regard to non-driving positions.

If you want to request driver insurability on multiple drivers, you may complete the following but we encourage you to screen prospective employees using the questions on page 1.

| Last | First | Middle Initial | P E* | C E* | Date of Birth | State of License | Driver's License Number | Relationship to Named Insured** |
|------|-------|----------------|---------|---------|---------------|------------------|-------------------------|---------------------------------|
| | | | | | | | | 1 2 3 4 5 6 |
| | | | | | | | | 1 2 3 4 5 6 |
| | | | | | | | | 1 2 3 4 5 6 |
| | | | | | | | | 1 2 3 4 5 6 |
| | | | | | | | | 1 2 3 4 5 6 |
| | | | | | | | | 1 2 3 4 5 6 |
| | | | | | | | | 1 2 3 4 5 6 |
| | | | | | | | | 1 2 3 4 5 6 |

* PE = Prospective Employee or CE = Current Employee - Place an "X" as applicable.*

** Please show Relationship to Named Insured, as indicated below, by circling the corresponding number above.

- 1. Owner (owner, partner, officer, director)
- 2. Owner's family member (spouse, dependent)
- 3. Heavy truck driver (2 ton trucks and heavier)
- 4. Driver or salesperson
- 5. All other-frequent use (not shown in 1 - 4 but often drives)
- 6. All other-infrequent use (not shown in 1 - 4 but rarely drives)

OFFICE USE ONLY - TO BE COMPLETED BY FEDERATED

- Insurable for driving vehicles
- Exceeds standards/uninsurable for driving vehicles
- Probationary - any more convictions or at-fault accidents change this driver to exceeds standards/uninsurable.
- No MVR found based on information provided. Please revise incorrect data and return to Federated if still desired.
- Comments

MVR Reviewer Name

CST/Dept

Date

SECTION 1:

TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name)

First, M.I., Last

Social Security Number

hereby authorize:

Date Of Birth

Previous Employer:

Email:

Street:

Telephone:

City, State, Zip:

Fax No.:

to release and forward the information requested by section 3 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from

To (date of employment application)

Prospective Employer:

Attention:

Telephone:

Street:

City, State, Zip:

In compliance with §40.25(g) and §391.23(h), release of this information must be made in a written form that ensures confidentiality, such as fax, email, or letter.

Prospective employer's confidential fax number:

Prospective employer's confidential email address:

Applicant's Signature

Date

This information is being requested in compliance with §40.25 and §391.23.

SECTION 2:

TO BE COMPLETED BY PREVIOUS EMPLOYER

ACCIDENT HISTORY

The applicant named above was employed by us. Yes [] No []

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

1. Did he/she drive motor vehicle for you? Yes [] No [] If yes, what type? Straight Truck [] Tractor-Semitrailer [] Bus [] Cargo Tank [] Doubles/Triples [] Other (Specify)

2. Reason for leaving your employ: Discharged [] Resignation [] Lay Off [] Military Duty []

If there is no safety performance history to report, check here [], sign below and return.

ACCIDENTS: Complete the following for any accidents included on your accident register (§390.15(b)) that involved the applicant in the 3 years prior to the application date shown above, or check here [] if there is no accident register data for this driver.

Table with 5 columns: Date, Location, No. of Injuries, No. of Fatalities, Hazmat Spill. Rows 1, 2, 3.

Please provide information concerning any other accidents involving the applicant that were reported to government agencies or insurers or retained under internal company policies:

Any other remarks:

Signature:

Title:

Date:

| | |
|--|---|
| SECTION 3: | TO BE COMPLETED BY PREVIOUS EMPLOYER |
| DRUG AND ALCOHOL HISTORY | |
| If driver was not subject to Department of Transportation testing requirements while employed by this employer, please check here <input type="checkbox"/> , fill in the dates of employment from _____ to _____, complete bottom of Section 3, sign, and return. | |
| Driver was subject to Department of Transportation testing requirements from _____ to _____. | |
| | YES NO |
| 1. Has this person had an alcohol test with a result of 0.04 or higher alcohol concentration? | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Has this person tested positive or adulterated or substituted a test specimen for controlled substances? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Has this person refused to submit to a post-accident, random, reasonable suspicion, or follow-up alcohol or controlled substance test? | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Has this person committed other violations of Subpart B of Part 382, or Part 40? | <input type="checkbox"/> <input type="checkbox"/> |
| 5. If this person has violated a DOT drug and alcohol regulation, did this person complete a SAP-prescribed rehabilitation program in your employ, including return-to-duty and follow-up tests? If yes, please send documentation back with this form. | <input type="checkbox"/> <input type="checkbox"/> |
| 6. For a driver who successfully completed a SAP's rehabilitation referral and remained in your employ, did this driver subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refuse to be tested? | <input type="checkbox"/> <input type="checkbox"/> |
| In answering these questions, include any DOT drug or alcohol testing information obtained from previous employers in the previous 3 years prior to the application date shown on side 1. | |
| Name: _____ | |
| Company: _____ | |
| Street: _____ | |
| City, State, Zip: _____ Telephone: _____ | |
| Section 3 Completed by (Signature): _____ Date: _____ | |

| | |
|---|--|
| SECTION 4a: | TO BE COMPLETED BY PROSPECTIVE EMPLOYER |
| This form was (check one) <input type="checkbox"/> Faxed to previous employer. <input type="checkbox"/> Mailed. ... <input type="checkbox"/> Emailed.. <input type="checkbox"/> Other _____ | |
| By: _____ Date: _____ | |

| | |
|--|---|
| SECTION 4b: | TO BE COMPLETED BY PROSPECTIVE EMPLOYER |
| Complete below when information is obtained. | |
| Information received from: _____ | |
| Recorded by: _____ | Method: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Email |
| Date: _____ | |

INSTRUCTIONS TO COMPLETE THE SAFETY PERFORMANCE HISTORY RECORDS REQUEST

SIDE 1 SECTION 1: Prospective Employee

- Complete the information required in this section
- Sign and date
- Submit to the Prospective Employer

SIDE 2 SECTION 4a: Prospective Employer

- Complete the information
- Send a copy to the Previous Employer

SIDE 1 SECTION 2: Previous Employer

- Complete the information required in this section
- Sign and Date
- complete SIDE 2 SECTION 3

SIDE 2 SECTION 3: Previous Employer

- Complete the information required in this section
- Sign and date
- Retain a copy
- Return original to Prospective Employer

SIDE 2 SECTION 4b: Prospective Employer

- Record receipt of the information
- Retain a copy