

Application for Employment

For Office Use Only

CC: _____

Date Rec'd: _____

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email Address: _____

Have you applied here before? Y / N Have you been employed here before? Y / N

Position Desired: _____ Salary Preferred: _____

Are you presently employed? Y / N, If yes, may we contact your employer? Y / N

Education History:

Grade Completed	School	Degree/Area of Study
	Elementary	
	High School	
	College	
	Graduate or Other:	

Employment Experience:

Term of Employment	Employer Name & Address	Supervisor's Name & Telephone No.	Salary	Position	Reason for Leaving

Special Skills or Area of Expertise: _____

*****NOTICE:** Successful applicants for employment will be given an offer of employment conditioned on the applicant receiving a negative test result from a drug test performed by a professional lab and satisfactory results from a physical screening to determine the applicants' physical capability to perform the functions of the position for which they are being hired, within 3 days of receiving a conditional offer of employment from S.D. Ireland. The applicant will receive a patient intake packet for Urgent Care Health Facility. The applicant will report to Urgent Care within 3 days of the offer to be tested. The test results will be reported confidentially to our Safety Director within 24 hours and the applicant will be notified of the result and if successful, when to report to work. "Drug" means a drug listed or classified by the U.S. Drug Enforcement Administration as a Schedule I drug, or its metabolites, and alcohol. It shall also mean other drugs or their metabolites which are likely to cause impairment of an individual on the job, which are: amitriptyline, amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, doxepin, glutethimide, hydromorphone, imipramine, meperidine, methadone, methaqualone, opiates, oxycodone, pentazocine, phenytoin, phencyclidine, phenothiazines, and propoxyphene. In addition, any drugs the commissioner of health may, pursuant to chapter 25 of Title 3, adds to this list not recognized as being commonly abused and likely to cause impairment of an employee on the job. Therapeutic levels of medically-prescribed drugs tested will not be reported.

S.D. Ireland is an Equal Opportunity Employer and in compliance with Federal Standards we ask that you check off the following at will:

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> White Male
(Not of Hispanic Origin) | <input type="checkbox"/> Black Male
(Not of Hispanic Origin) | <input type="checkbox"/> Hispanic
Male | <input type="checkbox"/> Asian or Pacific
Islander Male | <input type="checkbox"/> American Indian
or Alaskan Native Male |
| <input type="checkbox"/> White Female
(Not of Hispanic Origin) | <input type="checkbox"/> Black Female
(Not of Hispanic Origin) | <input type="checkbox"/> Hispanic
Female | <input type="checkbox"/> Asian or Pacific
Islander Female | <input type="checkbox"/> American Indian
or Alaskan Native Female |
| <input type="checkbox"/> Unknown Male | | <input type="checkbox"/> Unknown Female | | |

Authorization

I certify that I have read and comprehend all the information given and requested in this application and state that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, and release the company from all liability for any damage that may result from utilization of such information.

Date: _____ **Signature:** _____

Applications are valid for 30 days. If not hired within 30 days of submitting an application the applicant still wishes to be considered for a position, they will need to complete a new application and submit it. All applications must be submitted on an original application form. If an applicant wishes to apply for more than one position, a separate application must be filed for each position applied for.

APPLICATION FOR EMPLOYMENT

NAME _____
(FIRST) (MIDDLE) (Maiden Name, if any) (LAST)
 ADDRESS _____
(STREET) (CITY) (STATE & ZIP CODE) HOW LONG? _____
 DATE OF BIRTH _____ SOCIAL SECURITY NO. _____ HIRE DATE _____
 TELEPHONE NUMBER _____ E-MAIL ADDRESS _____

PREVIOUS THREE YEARS RESIDENCY

(STREET) CITY (STATE & ZIP CODE) # YEARS _____

(STREET) CITY (STATE & ZIP CODE) # YEARS _____

(STREET) CITY (STATE & ZIP CODE) # YEARS _____

(ATTACH SHEET IF MORE SPACE IS NEEDED)

LICENSE INFORMATION

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

STATE	LICENSE NO.	TYPE	EXPIRATION DATE

DRIVING EXPERIENCE

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

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

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

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

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

(ATTACH SHEET IF MORE SPACE IS NEEDED)

- A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES _____ NO _____
 If yes, explain _____
- B. Has any license, permit or privilege ever been suspended or revoked? YES _____ NO _____
 If yes, explain _____

EMPLOYMENT RECORD

(ATTACH SHEET IF MORE SPACE IS NEEDED)

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

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

LAST EMPLOYER: NAME _____

ADDRESS _____ PHONE _____

POSITION HELD _____ FROM _____ TO _____ SALARY _____

REASONS FOR LEAVING _____

ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON: _____

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

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

SECOND LAST EMPLOYER: NAME _____

ADDRESS _____ PHONE _____

POSITION HELD _____ FROM _____ TO _____ SALARY _____

REASONS FOR LEAVING _____

ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON: _____

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

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

THIRD LAST EMPLOYER: NAME _____

ADDRESS _____ PHONE _____

POSITION HELD _____ FROM _____ TO _____ SALARY _____

REASONS FOR LEAVING _____

ANY GAPS IN EMPLOYMENT AND/OR UNEMPLOYMENT MUST BE EXPLAINED. INCLUDE DATES (MONTH/YEAR) AND REASON: _____

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

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

TO BE READ AND SIGNED BY APPLICANT

I authorize you to make sure Investigations and Inquiries to my personal, employment, financial or medical history and other related matters as may be necessary in arriving at an employment decision. (Generally, inquiries regarding medical history will be made only if and after a conditional offer of employment has been extended.) I hereby release employers, schools, health care providers and other persons from all liability in responding to inquiries and releasing information in connection with my application.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Company.

"I understand that information I provide regarding current and/or previous employers may be used, and those employer(s) will be contacted, for the purpose of investigating my safety performance history as required by 49 CFR 391.23(d) and (e). I understand that I have the right to:

- Review information provided by current/previous employers:
- Have errors in the information corrected by previous employers and for those previous employers to re-send the corrected information to the prospective employer; and
- Have a rebuttal statement attached to the alleged erroneous information, if the previous employer(s) and I cannot agree on the accuracy of the information."

DATE

APPLICANTS SIGNATURE

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

DATE

APPLICANTS SIGNATURE

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

S.D. Ireland is an Equal Opportunity Employer.

SIDE 1 SAFETY PERFORMANCE HISTORY RECORDS REQUEST

RECIPIENT EMPLOYER: The individual identified in SECTION 1 below has indicated that you employ(ed) or use(d) him/her within the last 3 years in a position that involved the operation of a commercial motor vehicle and/or that was subject to U.S. Department of Transportation (DOT)-regulated drug and alcohol testing.

In accordance with 49 CFR §§40.25 and 391.23, we are hereby requesting that you supply us with the Safety Performance History of this individual. **Under DOT rule §391.23(g), you *must* respond to this inquiry within 30 days of receipt.**

Please complete SECTIONS 2 through 4 (as applicable) and return to the prospective employer shown in SECTION 1.

APPLICANT: Complete SECTION 1 and submit to prospective employer.

PROSPECTIVE EMPLOYER: Complete SECTION 5a and send form to current/previous employer. Upon receipt of completed form, complete SECTION 5b and retain.

SECTION 1:

TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name)

First, M.I., Last

hereby authorize:

Social Security Number

Date of Birth

Previous Employer:

Email:

Street:

Telephone:

City, State, Zip:

Fax No.:

to release and forward the information requested by section 4 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from _____
(date of employment application)

To:

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

SECTION 2:

TO BE COMPLETED BY PREVIOUS EMPLOYER

EMPLOYMENT VERIFICATION

The applicant named above was or is employed or used by us. Yes ☐ No ☐

Employed as (job title) _____ from (m/y) _____ to (m/y) _____

Did he/she drive a motor vehicle for you? Yes ☐ No ☐ If yes, what type? Straight Truck ☐ Tractor-Semitrailer ☐ Bus ☐

Cargo Tank ☐ Doubles/Triples ☐ Other (Specify) _____

Completed by:

Company:

Street:

City, State, Zip:

Telephone:

Signature:

Date:

If there is no safety performance history to report, check here ☐ and return. Otherwise, complete Sections 3 and 4 on SIDE 2 before returning.

SECTION 3:**TO BE COMPLETED BY PREVIOUS EMPLOYER****ACCIDENT HISTORY**

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 on SIDE 1 or check here ☐ if there is no accident register data for this driver.

Date	Location	No. of Injuries	No. of Fatalities	Hazmat Spill
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

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

SECTION 4:**TO BE COMPLETED BY PREVIOUS EMPLOYER****DRUG AND ALCOHOL HISTORY**

If applicant was **not** subject to DOT testing requirements under 49 CFR Part 40 while employed by you, please check here ☐ and return.

Applicant was subject to DOT testing requirements from _____ to _____.

In answering these questions, include any required DOT drug or alcohol testing information you obtained from other employers in the 3 years prior to the application date shown on SIDE 1.

Within the past 3 years from the application date shown on SIDE 1:

- | | YES | NO | |
|---|--------------------------|--------------------------|--------------------------|
| 1. Has this person violated any of the drug and/or alcohol prohibitions under 49 CFR Part 40 or Subpart B of Part 382, including: | <input type="checkbox"/> | <input type="checkbox"/> | |
| • An alcohol test with a result of 0.04 or higher alcohol concentration. | | | |
| • A controlled substances test result of positive, adulterated, or substituted. | | | |
| • A refusal to submit to a random, post-accident, reasonable-suspicion, or follow-up controlled substances or alcohol test. | | | |
| • Alcohol use while performing or within 4 hours before performing safety-sensitive functions. | | | |
| • Alcohol use after an accident, in violation of §382.303. | | | |
| • Controlled substances use while on duty, except as allowed under §382.213. | | | N/A |
| 2. If this person violated a DOT drug and/or alcohol prohibition, did he/she fail to begin or complete a rehabilitation program prescribed by a Substance Abuse Professional (SAP)? If rehabilitation was required but you do not know if he/she began or completed such a program, check here <input type="checkbox"/> . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If this person successfully completed a SAP's rehabilitation referral and remained in your employ, did he/she subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refusal to be tested? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION 5a:**TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

This form was (check one) ☐ Faxed to previous employer ☐ Mailed ☐ Emailed ☐ Other _____

By: _____ Date: _____

Subsequent attempts to contact previous employer (§391.23(c)(1)): _____

SECTION 5b:**TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

Complete below when information is obtained.

Information received from: _____

Recorded by: _____ Method: ☐ Fax ☐ Mail ☐ Email ☐ Telephone

Date: _____ ☐ Other _____

SIDE 1 SAFETY PERFORMANCE HISTORY RECORDS REQUEST

RECIPIENT EMPLOYER: The individual identified in SECTION 1 below has indicated that you employ(ed) or use(d) him/her within the last 3 years in a position that involved the operation of a commercial motor vehicle and/or that was subject to U.S. Department of Transportation (DOT)-regulated drug and alcohol testing.

In accordance with 49 CFR §§40.25 and 391.23, we are hereby requesting that you supply us with the Safety Performance History of this individual. **Under DOT rule §391.23(g), you must respond to this inquiry within 30 days of receipt.**

Please complete SECTIONS 2 through 4 (as applicable) and return to the prospective employer shown in SECTION 1.

APPLICANT: Complete SECTION 1 and submit to prospective employer.

PROSPECTIVE EMPLOYER: Complete SECTION 5a and send form to current/previous employer. Upon receipt of completed form, complete SECTION 5b and retain.

SECTION 1:

TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name)

First, M.I., Last

hereby authorize:

Social Security Number

Date of Birth

Previous Employer:

Email:

Street:

Telephone:

City, State, Zip:

Fax No.:

to release and forward the information requested by section 4 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from _____
(date of employment application)

To:

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

SECTION 2:

TO BE COMPLETED BY PREVIOUS EMPLOYER

EMPLOYMENT VERIFICATION

The applicant named above was or is employed or used by us. Yes ☐ No ☐

Employed as (job title) _____ from (m/y) _____ to (m/y) _____

Did he/she drive a motor vehicle for you? Yes ☐ No ☐ If yes, what type? Straight Truck ☐ Tractor-Semitrailer ☐ Bus ☐

Cargo Tank ☐ Doubles/Triples ☐ Other (Specify) _____

Completed by:

Company:

Street:

City, State, Zip:

Telephone:

Signature:

Date:

If there is no safety performance history to report, check here ☐ and return. Otherwise, complete Sections 3 and 4 on SIDE 2 before returning.

SECTION 3:**TO BE COMPLETED BY PREVIOUS EMPLOYER****ACCIDENT HISTORY**

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 on SIDE 1 or check here ☐ if there is no accident register data for this driver.

	Date	Location	No. of Injuries	No. of Fatalities	Hazmat Spill
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

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

SECTION 4:**TO BE COMPLETED BY PREVIOUS EMPLOYER****DRUG AND ALCOHOL HISTORY**

If applicant was **not** subject to DOT testing requirements under 49 CFR Part 40 while employed by you, please check here ☐ and return.
 Applicant was subject to DOT testing requirements from _____ to _____.

In answering these questions, include any required DOT drug or alcohol testing information you obtained from other employers in the 3 years prior to the application date shown on SIDE 1.

Within the past 3 years from the application date shown on SIDE 1:

- | | YES | NO | |
|--|--------------------------|--------------------------|--------------------------|
| 1. Has this person violated any of the drug and/or alcohol prohibitions under 49 CFR Part 40 or Subpart B of Part 382, including: | <input type="checkbox"/> | <input type="checkbox"/> | |
| <ul style="list-style-type: none"> • An alcohol test with a result of 0.04 or higher alcohol concentration. • A controlled substances test result of positive, adulterated, or substituted. • A refusal to submit to a random, post-accident, reasonable-suspicion, or follow-up controlled substances or alcohol test. • Alcohol use while performing or within 4 hours before performing safety-sensitive functions. • Alcohol use after an accident, in violation of §382.303. • Controlled substances use while on duty, except as allowed under §382.213. | | | |
| 2. If this person violated a DOT drug and/or alcohol prohibition, did he/she fail to begin or complete a rehabilitation program prescribed by a Substance Abuse Professional (SAP)? If rehabilitation was required but you do not know if he/she began or completed such a program, check here <input type="checkbox"/> . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If this person successfully completed a SAP's rehabilitation referral and remained in your employ, did he/she subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refusal to be tested? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION 5a:**TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

This form was (check one) ☐ Faxed to previous employer ☐ Mailed ☐ Emailed ☐ Other _____

By: _____ Date: _____

Subsequent attempts to contact previous employer (§391.23(c)(1)):

SECTION 5b:**TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

Complete below when information is obtained.

Information received from: _____

Recorded by: _____ Method: ☐ Fax ☐ Mail ☐ Email ☐ Telephone

Date: _____ ☐ Other _____

SIDE 1 SAFETY PERFORMANCE HISTORY RECORDS REQUEST

RECIPIENT EMPLOYER: The individual identified in SECTION 1 below has indicated that you employ(ed) or use(d) him/her within the last 3 years in a position that involved the operation of a commercial motor vehicle and/or that was subject to U.S. Department of Transportation (DOT)-regulated drug and alcohol testing.

In accordance with 49 CFR §§40.25 and 391.23, we are hereby requesting that you supply us with the Safety Performance History of this individual. **Under DOT rule §391.23(g), you *must* respond to this inquiry within 30 days of receipt.**

Please complete SECTIONS 2 through 4 (as applicable) and return to the prospective employer shown in SECTION 1.

APPLICANT: Complete SECTION 1 and submit to prospective employer.

PROSPECTIVE EMPLOYER: Complete SECTION 5a and send form to current/previous employer. Upon receipt of completed form, complete SECTION 5b and retain.

SECTION 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name)	First, M.I., Last	hereby authorize:	Social Security Number
Previous Employer:			Date of Birth
Street:			Email:
City, State, Zip:			Telephone:
			Fax No.:
to release and forward the information requested by section 4 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from _____ (date of employment application)			
To:			
Prospective Employer:	S.D. Ireland Concrete		
Attention:	Nicole Kittle	Telephone:	803-6277
Street:	P.O. Box 2786		
City, State, Zip:	South Burlington, VT 05407		
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:		802-419-3737	
Prospective employer's confidential email address: _____			
Applicant's Signature			Date

SECTION 2: TO BE COMPLETED BY PREVIOUS EMPLOYER

EMPLOYMENT VERIFICATION

The applicant named above was or is employed or used by us. Yes ☐ No ☐

Employed as (job title) _____ from (m/y) _____ to (m/y) _____

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

Completed by: _____

Company: _____

Street: _____

City, State, Zip: _____ Telephone: _____

Signature: _____ Date: _____

If there is no safety performance history to report, check here ☐ and return. Otherwise, complete Sections 3 and 4 on SIDE 2 before returning.

SECTION 3:**TO BE COMPLETED BY PREVIOUS EMPLOYER****ACCIDENT HISTORY**

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 on SIDE 1 or check here ☐ if there is no accident register data for this driver.

Date	Location	No. of Injuries	No. of Fatalities	Hazmat Spill
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

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

SECTION 4:**TO BE COMPLETED BY PREVIOUS EMPLOYER****DRUG AND ALCOHOL HISTORY**

If applicant was **not** subject to DOT testing requirements under 49 CFR Part 40 while employed by you, please check here ☐ and return.
 Applicant was subject to DOT testing requirements from _____ to _____.

In answering these questions, include any required DOT drug or alcohol testing information you obtained from other employers in the 3 years prior to the application date shown on SIDE 1.

Within the past 3 years from the application date shown on SIDE 1:

- | | YES | NO | |
|---|--------------------------|--------------------------|--------------------------|
| 1. Has this person violated any of the drug and/or alcohol prohibitions under 49 CFR Part 40 or Subpart B of Part 382, including: | <input type="checkbox"/> | <input type="checkbox"/> | |
| • An alcohol test with a result of 0.04 or higher alcohol concentration. | | | |
| • A controlled substances test result of positive, adulterated, or substituted. | | | |
| • A refusal to submit to a random, post-accident, reasonable-suspicion, or follow-up controlled substances or alcohol test. | | | |
| • Alcohol use while performing or within 4 hours before performing safety-sensitive functions. | | | |
| • Alcohol use after an accident, in violation of §382.303. | | | |
| • Controlled substances use while on duty, except as allowed under §382.213. | | | N/A |
| 2. If this person violated a DOT drug and/or alcohol prohibition, did he/she fail to begin or complete a rehabilitation program prescribed by a Substance Abuse Professional (SAP)? If rehabilitation was required but you do not know if he/she began or completed such a program, check here <input type="checkbox"/> . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If this person successfully completed a SAP's rehabilitation referral and remained in your employ, did he/she subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refusal to be tested? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION 5a:**TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

This form was (check one) ☐ Faxed to previous employer ☐ Mailed ☐ Emailed ☐ Other _____

By: _____ Date: _____

Subsequent attempts to contact previous employer (§391.23(c)(1)): _____

SECTION 5b:**TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

Complete below when information is obtained.

Information received from: _____

Recorded by: _____ Method: ☐ Fax ☐ Mail ☐ Email ☐ Telephone

Date: _____ ☐ Other _____

PLEASE COMPLETE EVERYTHING IN RED

Request for Check of Driving Record

Under the Fair Credit Reporting Act ("FCRA"), 15 U.S.C. § 1681 et seq., the regulations applicable to the federal Department of Transportation's Federal Motor Carriers Safety Administration, including 49 CFR § 40.329, the Americans with Disabilities Act and all other applicable federal, state, and local laws, I hereby authorize and permit, my employer, S.D. Ireland Companies to obtain information periodically, where permitted, pertaining to my driving history records. You are released from any and all liability, which may result from furnishing such information.

Applicant's/Employee's Signature

Date

1. In accordance with the provisions of Section 604 and Section 607 of the Fair Credit Reporting Act, Public Law No. 91-508, I hereby certify that the information requested below will be used for a "permissible purpose" as defined in the Act, and that the information received will be used for no other purpose.
2. I further certify that if the applicant named below is denied employment based upon the information received, I will identify the source of the report in accordance with Section 615(a) of the Fair Credit Reporting Act.

(Signature of Requester) S.D. Ireland Representative

(Date)

NAME OF APPLICANT: _____

ADDRESS: _____

FORMER ADDRESS: _____

DATE OF BIRTH: _____

LICENSE NUMBER: _____

**MOTOR VEHICLE
DRIVER'S CERTIFICATION
OF VIOLATORS
391.27**

I certify that the following is a 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 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 12 months.

S.D. Ireland
(Motor Carrier's Name)

(Driver's Signature)

193 Industrial Avenue, Williston, VT 05495
(Motor Carrier's Address)

(Driver's Printed Name)

(Reviewed by: Signature and Title)

(Date of Certification)