

EMPLOYEE ACKNOWLEDGEMENT FORM

1. I, _____ employee of Collins Trucking Company, Inc., acknowledge that I have been shown the Workers' Compensation panel of physicians which is posted _____.
2. I acknowledge that my employer has explained to me the function of this panel of physicians and I am to utilize only the physicians listed on this panel if I am injured on the job.
3. I understand that in the event I am injured, I am required to notify a supervisor or other person in a position of authority and that I am required to choose a doctor from those listed on the panel of physicians.
4. I understand I can receive emergency medical care outside of the physicians listed in these panels, only for as long as the emergency exists. After which I am to see follow up care from one of the physicians on the list. If I must seek emergency care from a doctor other than those listed, I must notify my employer.
5. I understand that if I am dissatisfied with the physician that I have chosen from this panel, then I have the right to change to another doctor on this panel. I understand that I am only allowed to make this change one time without permission of my employer, the insurance carrier, or the State Board of Workers' Compensation. I also understand that any further changes must be made with the consent of my employer, the insurance carrier, and the State Board of Workers' Compensation.
6. I understand my employer will provide me with the necessary and appropriate assistance in contacting the doctors listed on this panel and I am obligated to notify my employer if assistance is required in contacting these doctors.
7. I understand if I seek the treatment of a doctor not listed on this panel and not in an emergency situation, that I am solely responsible for that doctor's charges.

I acknowledge that I have read, or have been read to by my employer, the above rights under the Workers' Compensation Act and I completely understand those rights.

Employee's Signature

Date

Witness

Date



HireRight Customer:
 Company Name: **Collins Trucking Company, Inc.**
 Company Contact Name: **Mike Chupp**
 Fax #: **(678) 774- 0017**
 HireRight Account Code: **HPGQN**

TRUCKING INDUSTRY:
DOT D/A Disclosure and Authorization

Send to Fax# (800) 257-8069

PART I – DISCLOSURE AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT PURPOSES – 49 CFR PART 391.23, DOT DRUG AND ALCOHOL TESTING

In accordance with DOT Regulation 49 CFR Part 391.23, I hereby authorize release of my DOT-regulated drug and alcohol testing records by the DOT-regulated employer(s) listed below to HireRight for the purpose of HireRight transmitting such records to the HireRight customer listed above. I understand that information/documents released pursuant to this Part I is limited to the following DOT-regulated testing items, including pre-employment testing results, occurring during the previous **three (3) years**: (i) alcohol tests with a result of 0.04 or higher; (ii) verified positive drug tests; (iii) refusals to be tested (including adulterated and/ or substituted tests); (iv) other violations of DOT drug and alcohol testing regulations (i.e., violations of 49 CFR 382 Subpart B); (v) information obtained from previous employers of a drug and alcohol rule violation; and (vi) any documentation of completion of the return-to-duty process following a rule violation.

If any company listed below furnishes HireRight with information concerning items (i) through (vi) above, I also authorize such company to furnish the following information to HireRight, if applicable: (i) dates of my negative drug and/or alcohol tests and/or tests with results below 0.04 during the previous **three (3) years**; and (ii) the name and phone number of any substance abuse professional who evaluated me during the previous **three (3) years**.

List all DOT-regulated employers you have applied with and/or worked for in a safety-sensitive function during the previous **three (3) years**. If necessary, attach additional pages, including the date, your name, social security number and signature.

Previous DOT-Regulated Employer	City	State	Phone Number
_____	_____	_____	(____) _____ - _____
_____	_____	_____	(____) _____ - _____
_____	_____	_____	(____) _____ - _____
_____	_____	_____	(____) _____ - _____
_____	_____	_____	(____) _____ - _____

By signing below, I certify that: (i) all information provided herein is complete and accurate; (ii) I have read and fully understand this Part I disclosure and authorization for release as well as the attached FMCSA Notification of Driver Rights and any applicable state law notices; (iii) prior to signing I was given an opportunity to ask questions and to have those questions answered to my satisfaction; (iv) I execute this authorization voluntarily and with the knowledge that the information obtained pursuant to this authorization could affect my eligibility for employment, promotion, retention or other lawful purpose; (v) I understand I may review this document with legal counsel prior to signing; and (vi) facsimile or photographic copies of this authorization are as valid as an original.

Print Applicant Name: _____ Social Security #: _____

Applicant Signature: _____ Date: _____

PRE-EMPLOYMENT SUBSTANCE ABUSE TESTING RELEASE

PLEASE READ CAREFULLY

I freely and voluntarily agree to submit to a urinalysis Drug Screen Test as a part of my application to be considered for employment, either as a regular part time, full time, company employee or contractor for Collins Trucking Company, Inc. I understand that either a refusal to submit to the urinalysis screen or failure to qualify according to the minimum standards established by Federal and State Regulations for this screen will disqualify me from further consideration for such employment.

I further understand that upon commencement of employment with Collins Trucking Company, Inc. I may again be required to submit a urinalysis screen. I understand that a refusal to take a requested urinalysis screen, the submitting of an adulterated specimen, or the failure to meet minimum standards for the screen, will result in immediate termination.

I have read in full and understand the above statements and conditions as set forth above.

Applicant Signature

Date

Driver's License Information:

Driver's License Number

State of Issue

Expiration Date



COLLINS TRUCKING COMPANY, INC. JOB DESCRIPTION

ALL REQUIREMENTS APPLY REGARDLESS OF COMPANY DRIVER OR OWNER-OPERATOR POSITION.

1. Over the road flatbed
2. Regional flatbed
3. Over the road van
4. Regional logging/core hauling

Please read the following duty requirements completely, making sure that you thoroughly understand what will be required of you while working for Collins Trucking Company, Inc. as a company employee, a driver for any owner-operator, or as the owner-operator.

You must:

1. Represent Collins Trucking Company, Inc. in a professional manner with a positive attitude, appropriate dress code, and a neat personal appearance.
2. Effectively be able to read and write the English language in order to communicate with any customer or company employee.
3. Be mentally able to understand instructions and follow them.
4. Be mentally and physically able to report to work each week.
5. Be able to complete any paperwork for the effective control of any federal motor carrier or company requirements.
6. Physically, effectively, and safely be able to drive a semi-tractor equipped with a forty eight (48) or fifty three (53) foot trailer over any county, state, or federal highway at posted speed limits in a sitting position for periods of time from a minimum of fifteen (15) minutes to a maximum of eleven (11) hours within a fourteen (14) hour period.
7. Be able to dolly, raise, and lower a trailer throughout a workday as many times as dispatch deems necessary.
8. Be physically able to secure any loads by use of straps, cables, or chains to the trailer.
9. Be physically able to lift two (2) twenty seven foot by twenty-four (24) foot medium weight lumber tarps weighing between fifty (50) to seventy-five (75) pounds each from ground level to the deck of the trailer which is approximately five (5) feet and or from the deck of the trailer to the top of the freight which could be from one (1) foot to six (6) feet above the deck of the trailer for time periods ranging from a minimum of one (1) hour to a maximum of three (3) hours within a fourteen (14) hour period to apply any protective covering, whether a tarp or poly film, over any load that requires protection from the elements, as specified by any customer of Collins Trucking Company, Inc.

10. Be physically able to open and close the doors at the rear of a fifty three (53) foot van when at the shipper or consignee dock for loading or unloading.
11. Effectively plan a trip through the use of a map or company Qualcomm in order to travel over the most direct and safest route for the delivery of freight while eliminating excessive out of route miles.
12. Consistently pickup and deliver freight on time with the only exceptions being any act beyond your control.
13. Keep an open line of communication with dispatch. Failure to perform and refusal of loads are grounds for termination.
14. Be able to deal with any customer in a professional business manner while avoiding any type of confrontation and to follow any safety policies while on their property.

I acknowledge having read the above and that I thoroughly understand the requirements of the position. Failure to follow any company policy or aggressive actions towards customers are reasons for termination.

Applicant Signature

Date

I, _____, hereby provide consent to Collins Trucking Company, Inc. to conduct a query of the FMCSA Commercial Driver's License Drug and Alcohol Clearinghouse to determine whether drug or alcohol violation information about me exists in the Clearinghouse. By signing this consent form you are giving Collins Trucking Company, Inc. consent to request a query in your name through the Clearinghouse portal.

I understand that if the query conducted by Collins Trucking Company, Inc. indicates that drug and alcohol violation information about me exists in the Clearinghouse, FMCSA will not disclose that information to Collins Trucking Company, Inc. without first obtaining additional specific consent from me.

I further understand that if I refuse to consent for Collins Trucking Company, Inc. to conduct a query of the Clearinghouse, Collins Trucking Company, Inc. must prohibit me from performing safety-sensitive functions, including driving a commercial motor vehicle, as required by FMCSA's drug and alcohol regulations.

Employee Signature

Date



U.S. Department of Transportation

Federal Motor Carrier Safety Administration

F M C S A Federal Motor Carrier Safety Administration

www.fmcsa.dot.gov

AUTHORIZATION FOR RELEASE OF INFORMATION

APPLICANT IDENTIFICATION
Name: _____
Date of Birth: _____

<p>Protected Health Information: Any information that can be linked back to the individual applicant, can be in any form: written, electronic, or verbal.</p>
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<p>(Signed original will be placed in the applicant's record and a copy provided to the applicant)</p>
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I _____, authorize the Federal Motor Carrier Safety Administration ("FMCSA" or "the Agency") to disclose, in a public docket accessible to all interested parties via the Internet, medical records and information related to my application for an exemption from one or more of the physical qualifications standards under 49 CFR 391.41. I understand that the medical records and information that will be disclosed by the Agency may include specific health information related to the medical conditions or illnesses, injuries, diagnosis, prognosis and medical treatment provided to me which have resulted in my not being able to obtain a medical certificate to operate commercial motor vehicles in interstate commerce. I understand that the American Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain protections against the release of my personal medical records and information and hereby waive all protections provided by HIPAA with regard to medical records and information related to my application for an exemption from certain requirements under 49 CFR 391.41.

Please check and initial the statement that applies:

I do _____ I do not _____ authorize this information to be released.

Information Limitations, if any:

This information may also be shared with (please check one of the following):

1. Legal Representative _____

2 Other (please specify):

Please note this document has two pages, you are required to read and complete information on both documents, the last page will require your complete signature first/last name and date.

Description of the exemption being sought and the medical information to be released to FMCSA in support of the exemption application, including the healthcare professionals responsible for providing the records that will be released.

I understand that I may refuse to sign this authorization and that my refusal to sign may affect my ability to obtain an exemption with the FMCSA. I understand that I may withdraw my application for an exemption at any time and that I may revoke this authorization in writing at any time prior to the FMCSA publishing a notice in the Federal Register soliciting public comments on my exemption application. I understand that after FMCSA publishes a notice in the Federal Register all medical records and information submitted to FMCSA will be submitted to a public docket accessible by all interested parties via the Internet. The Agency will not remove information from the public docket after it has been posted.

Applicant's Address Signing person Name, Address & Telephone #:

Name(s) _____

Address _____

Telephone # _____

Request sent to:

1. Physician Company Person Other (explain)

2. Address: _____

3. Phone Number: _____ Fax #: _____

* Signature of Applicant Signing Person Legal Representative:

_____ Date: _____

Relationship to applicant: _____

All Facilities/persons listed on pages 1, 2 of this form may share information among and between themselves for the FMCSA assessment and Quality Assurance. Please sign above to authorize.