Driver's Application for Employment

Company:_____ Street Address:_____

City, State and Zip Code:_____

DRIVER APPLICANT ONLY

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 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.

Signature _____ Date _____

Applicant information:

Name: _____
(First) (Middle) (Maiden, if any) (Last)

Address: _____
(Street) (City) (State) (Zip) (How Long?)

Date of Birth:_____

Previous addresses : (If at the above address for less than three years)

Address: _____
(Street) (City) (State) (Zip) (How Long?)

Address: _____
(Street) (City) (State) (Zip) (How Long?)

(Attach additional sheet if necessary)

Experience and Qualifications-Driver

	State	License No.	Type and endorsements	Expiration Date
Driver Licenses				

Driving Experience

Class of equipment:	Type of equipment (Van, Tank, Flatbed, etc.)	Dates (From)	(To)	Approximate # of Miles (total)
Straight truck				
Tractor and semitrailer				
Tractor-Two trailers				
Other				

Accident record for past three years (attach additional sheet if necessary)

Dates	Nature of accident	Fatalities	Injuries
Last accident			
Next previous			
Next previous			

Traffic convictions (other than parking violations) and forfeitures for the past three years
(Attach additional sheet if more space is needed)

Location	Date	Charge	Penalty

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? Yes_____ No_____

B. Has any license, permit or privilege ever been suspended, revoked or denied? Yes_____ No_____

If the answer to either A or B is yes, explain: (attach additional sheet if necessary)

_____

_____

_____

Employment Record (attach additional sheet(s) if more space is needed)

You are required to give all employment information for at least three years.

If you are applying for a position that requires a CDL you will need to list all employment where you operated vehicles requiring a CDL for the past **ten** years.

Last employer:

Name_____

Address_____

Position held_____ Supervisor_____ Dates: _____
(from) (to)

Salary_____ Reasons for leaving_____

Was this employer subject to Federal (or PUC) Motor Carrier Safety Regulations? Yes_____No_____

Were you subject to controlled substance & alcohol testing under 49 CFR Parts 40/382 while employed here? Yes_____No_____

Employer:

Name_____

Address_____

Position held_____ Supervisor_____ Dates: _____
(from) (to)

Salary_____ Reasons for leaving_____

Was this employer subject to Federal (or PUC) Motor Carrier Safety Regulations? Yes_____No_____

Were you subject to controlled substance & alcohol testing under 49 CFR Parts 40/382 while employed here? Yes_____No_____

Employer:

Name_____

Address_____

Position held_____ Supervisor_____ Dates: _____
(from) (to)

Salary____________________ Reasons for leaving____

Was this employer subject to Federal (or PUC) Motor Carrier Safety Regulations? Yes_____No_____

Were you subject to controlled substance & alcohol testing under 49 CFR Parts 40/382 while employed here? Yes_____No_____

Employer: Name____

Address____

Position held______________________ Supervisor______________ Dates: ________________________ (from) (to)

Salary____________________ Reasons for leaving____

Was this employer subject to Federal (or PUC) Motor Carrier Safety Regulations? Yes_____No_____

Were you subject to controlled substance & alcohol testing under 49 CFR Parts 40/382 while employed here? Yes_____No_____

Employer: Name____

Address____

Position held______________________ Supervisor______________ Dates: ________________________ (from) (to)

Salary____________________ Reasons for leaving____

Was this employer subject to Federal (or PUC) Motor Carrier Safety Regulations? Yes_____No_____

Were you subject to controlled substance & alcohol testing under 49 CFR Parts 40/382 while employed here? Yes_____No_____

Employer: Name____

Address____

Position held______________________ Supervisor______________ Dates: ________________________ (from) (to)

Salary____________________ Reasons for leaving____

Was this employer subject to Federal (or PUC) Motor Carrier Safety Regulations? Yes_____No_____

Were you subject to controlled substance & alcohol testing under 49 CFR Parts 40/382 while employed here? Yes_____No_____

To be read and signed by applicant:

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

(Date)____________________ (Applicant's 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.

MEDICAL EXAMINER'S CERTIFICATE/ DRIVER MEDICAL CERTIFICATION CARD

Driver's Name: _____ Date of Examination: _____

I certify that I am a doctor of medicine or osteopathy, a physician assistant, nurse practitioner, or clinical nurse specialist working under the direct supervision of a physician. I have examined _____. Based upon all circumstances known to me, I certify as follows:

☐ This person is medically fit to drive for a motor carrier of passengers without condition .

☐ This person is medically fit to drive for a motor carrier of passengers, subject to the condition(s) listed below.

_____

☐ This person is medically fit to drive for a motor carrier of passengers, only if accompanied by a _____waiver (i.e. PUC Vision Waiver, etc). In my medical opinion, based upon all circumstances known to me including the medical condition(s) requiring an accompanying waiver, the established medical history or clinical diagnosis is not likely to interfere with the person's ability to control and drive a motor vehicle safely.

☐ This person is NOT medically fit to drive AND should NOT be issued a medical waiver.

The term of the certification is based on certification requirements and the medical examination. This certification is for a term of 2 (two) years from the date of issuance unless an earlier expiration date is specified here:

☐ 1 Year ☐ 6 Months ☐ Other: _____

The information I have provided regarding this examination is true and complete. A complete form with any attachments embodies my findings completely and correctly, and is on file in my office.

_____	_____	_____
Signature of Medical Examiner	Telephone	Date of Issuance
_____	_____	_____
Name of Medical Examiner (Print)	Medical License No./Issuing State	Title

A copy of this Medical Examiner's Certificate must be kept on the driver's person at all times that the named driver is operating a vehicle for a motor carrier of passengers.

For drivers of vehicles with a seating capacity of 15 passengers or less, including the driver. Drivers of vehicles with a seating capacity of 16 passengers or more, including the driver MUST use U.S. DOT Form MCSA-5875.