

# DRIVER'S APPLICATION FOR EMPLOYMENT

Applicant Name \_\_\_\_\_ Date of Application \_\_\_\_\_  
(print)

Company RES Inc.

Address PO Box 598

City Ripley State MS Zip 38663

In compliance with Federal and State equal employment opportunity laws, qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital status, veteran status, non-job related disability, or any other protected group status.

## TO BE READ AND SIGNED BY APPLICANT

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 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 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 X Date \_\_\_\_\_

## FOR COMPANY USE

### PROCESS RECORD

APPLICANT HIRED \_\_\_\_\_ REJECTED \_\_\_\_\_

DATE EMPLOYED \_\_\_\_\_ POINT EMPLOYED \_\_\_\_\_

DEPARTMENT \_\_\_\_\_ CLASSIFICATION \_\_\_\_\_  
(IF REJECTED, SUMMARY REPORT OF REASONS SHOULD BE PLACED IN FILE)

SIGNATURE OF INTERVIEWING OFFICER \_\_\_\_\_

## TERMINATION OF EMPLOYMENT

DATE TERMINATED \_\_\_\_\_ DEPARTMENT RELEASED FROM \_\_\_\_\_

DISMISSED \_\_\_\_\_ VOLUNTARILY QUIT \_\_\_\_\_ OTHER \_\_\_\_\_

TERMINATION REPORT PLACED IN FILE \_\_\_\_\_ SUPERVISOR \_\_\_\_\_

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# APPLICANT TO COMPLETE

(answer all questions - please print)

Position(s) Applied for \_\_\_\_\_

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Last First Middle

List your addresses of residency for the past 3 years.

Current Address \_\_\_\_\_  
Street City

Previous \_\_\_\_\_  
Addresses State Zip Code Phone How Long? \_\_\_\_\_  
yr./mo.

Street City State & Zip Code How Long? \_\_\_\_\_  
yr./mo.

Street City State & Zip Code How Long? \_\_\_\_\_  
yr./mo.

Street City State & Zip Code How Long? \_\_\_\_\_  
yr./mo.

Do you have the legal right to work in the United States? \_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Can you provide proof of age? \_\_\_\_\_  
(Required for Commercial Drivers)

Have you worked for this company before? \_\_\_\_\_ Where? \_\_\_\_\_

Dates: From \_\_\_\_\_ To \_\_\_\_\_ Rate of Pay \_\_\_\_\_ Position \_\_\_\_\_

Reason for leaving \_\_\_\_\_

Are you now employed? \_\_\_\_\_ If not, how long since leaving last employment? \_\_\_\_\_

Who referred you? \_\_\_\_\_ Rate of pay expected \_\_\_\_\_

Have you ever been bonded? \_\_\_\_\_ Name of bonding company \_\_\_\_\_  
(Answer only if a job requirement)

Have you ever been convicted of a felony? \_\_\_\_\_

If yes, please explain fully on a separate sheet of paper. Conviction of a crime is not an automatic bar to employment-all circumstances will be considered.

Is there any reason you might be unable to perform the functions of the job for which you have applied [as described in the attached job description]?

If yes, explain if you wish.

## EMPLOYMENT HISTORY

All driver applicants to drive in interstate commerce must provide the following information on all employers during the preceding 3 years. List complete mailing address, street number, city, state and zip code.

Applicants to drive a commercial motor vehicle\* in intrastate or interstate commerce shall also provide an additional 7 years' information on those employers for whom the applicant operated such vehicle.

(NOTE: List employers in reverse order starting with the most recent. Add another sheet as necessary.)

| EMPLOYER                                                                                                                                                                                                          |              | DATE               |               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------|---------------|
| NAME                                                                                                                                                                                                              |              | FROM<br>MO. YR.    | TO<br>MO. YR. |
| ADDRESS                                                                                                                                                                                                           |              | POSITION HELD      |               |
| CITY                                                                                                                                                                                                              | STATE ZIP    | SALARY/WAGE        |               |
| CONTACT PERSON                                                                                                                                                                                                    | PHONE NUMBER | REASON FOR LEAVING |               |
| WERE YOU SUBJECT TO THE FMCSRs <sup>†</sup> WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |              |                    |               |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO |              |                    |               |

## EMPLOYMENT HISTORY (continued)

| EMPLOYER                                                                                                                                                                                                          |                | DATE                 |                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------|--------------------|
| NAME                                                                                                                                                                                                              |                | FROM<br>MO.      YR. | TO<br>MO.      YR. |
| ADDRESS                                                                                                                                                                                                           |                | POSITION HELD        |                    |
| CITY                                                                                                                                                                                                              | STATE      ZIP | SALARY/WAGE          |                    |
| CONTACT PERSON                                                                                                                                                                                                    | PHONE NUMBER   | REASON FOR LEAVING   |                    |
| WERE YOU SUBJECT TO THE FMCSRs <sup>†</sup> WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |                |                      |                    |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO |                |                      |                    |

| EMPLOYER                                                                                                                                                                                                          |                | DATE                 |                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------|--------------------|
| NAME                                                                                                                                                                                                              |                | FROM<br>MO.      YR. | TO<br>MO.      YR. |
| ADDRESS                                                                                                                                                                                                           |                | POSITION HELD        |                    |
| CITY                                                                                                                                                                                                              | STATE      ZIP | SALARY/WAGE          |                    |
| CONTACT PERSON                                                                                                                                                                                                    | PHONE NUMBER   | REASON FOR LEAVING   |                    |
| WERE YOU SUBJECT TO THE FMCSRs <sup>†</sup> WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |                |                      |                    |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO |                |                      |                    |

| EMPLOYER                                                                                                                                                                                                          |                | DATE                 |                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------|--------------------|
| NAME                                                                                                                                                                                                              |                | FROM<br>MO.      YR. | TO<br>MO.      YR. |
| ADDRESS                                                                                                                                                                                                           |                | POSITION HELD        |                    |
| CITY                                                                                                                                                                                                              | STATE      ZIP | SALARY/WAGE          |                    |
| CONTACT PERSON                                                                                                                                                                                                    | PHONE NUMBER   | REASON FOR LEAVING   |                    |
| WERE YOU SUBJECT TO THE FMCSRs <sup>†</sup> WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |                |                      |                    |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO |                |                      |                    |

| EMPLOYER                                                                                                                                                                                                          |                | DATE                 |                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------|--------------------|
| NAME                                                                                                                                                                                                              |                | FROM<br>MO.      YR. | TO<br>MO.      YR. |
| ADDRESS                                                                                                                                                                                                           |                | POSITION HELD        |                    |
| CITY                                                                                                                                                                                                              | STATE      ZIP | SALARY/WAGE          |                    |
| CONTACT PERSON                                                                                                                                                                                                    | PHONE NUMBER   | REASON FOR LEAVING   |                    |
| WERE YOU SUBJECT TO THE FMCSRs <sup>†</sup> WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |                |                      |                    |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO |                |                      |                    |

| EMPLOYER                                                                                                                                                                                                          |                | DATE                 |                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------|--------------------|
| NAME                                                                                                                                                                                                              |                | FROM<br>MO.      YR. | TO<br>MO.      YR. |
| ADDRESS                                                                                                                                                                                                           |                | POSITION HELD        |                    |
| CITY                                                                                                                                                                                                              | STATE      ZIP | SALARY/WAGE          |                    |
| CONTACT PERSON                                                                                                                                                                                                    | PHONE NUMBER   | REASON FOR LEAVING   |                    |
| WERE YOU SUBJECT TO THE FMCSRs <sup>†</sup> WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                              |                |                      |                    |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO |                |                      |                    |

\*Includes vehicles having a GVWR of 26,001 lbs. or more, vehicles designed to transport 16 or more passengers (including the driver), or any size vehicle used to transport hazardous materials in a quantity requiring placarding.

<sup>†</sup>The Federal Motor Carrier Safety Regulations (FMCSRs) apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle: (1) weighs or has a GVWR of 10,001 pounds or more, (2) is designed or used to transport more than 8 passengers (including the driver), OR (3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED) IF NONE, WRITE **NONE**

| DATES               | NATURE OF ACCIDENT<br>(HEAD-ON, REAR-END, UPSET, ETC.) | FATALITIES | INJURIES | HAZARDOUS<br>MATERIAL SPILL |
|---------------------|--------------------------------------------------------|------------|----------|-----------------------------|
| LAST ACCIDENT _____ |                                                        |            |          |                             |
| NEXT PREVIOUS _____ |                                                        |            |          |                             |
| NEXT PREVIOUS _____ |                                                        |            |          |                             |

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS) IF NONE, WRITE **NONE**

| LOCATION | DATE | CHARGE | PENALTY |
|----------|------|--------|---------|
|          |      |        |         |
|          |      |        |         |
|          |      |        |         |

(ATTACH SHEET IF MORE SPACE IS NEEDED)

**EXPERIENCE AND QUALIFICATIONS – DRIVER**

List all driver licenses or permits held in the past 3 years

| DRIVER<br>LICENSES | STATE | LICENSE NO. | TYPE | EXPIRATION DATE |
|--------------------|-------|-------------|------|-----------------|
|                    |       |             |      |                 |
|                    |       |             |      |                 |
|                    |       |             |      |                 |

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 or revoked? YES \_\_\_\_\_ NO \_\_\_\_\_

IF THE ANSWER TO EITHER A OR B IS YES, GIVE DETAILS \_\_\_\_\_

\_\_\_\_\_

**DRIVING EXPERIENCE** CHECK YES OR NO

| CLASS OF EQUIPMENT                                                                                                            | CIRCLE TYPE OF EQUIPMENT       | DATES      |          | APPROX. NO. OF MILES<br>(TOTAL) |
|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------|----------|---------------------------------|
|                                                                                                                               |                                | FROM (M/Y) | TO (M/Y) |                                 |
| STRAIGHT TRUCK _____ <input type="checkbox"/> YES <input type="checkbox"/> NO                                                 | (VAN, TANK, FLAT, DUMP, REFER) |            |          |                                 |
| TRACTOR AND SEMI-TRAILER _____ <input type="checkbox"/> YES <input type="checkbox"/> NO                                       | (VAN, TANK, FLAT, DUMP, REFER) |            |          |                                 |
| TRACTOR - TWO TRAILERS _____ <input type="checkbox"/> YES <input type="checkbox"/> NO                                         | (VAN, TANK, FLAT, DUMP, REFER) |            |          |                                 |
| TRACTOR - THREE TRAILERS _____ <input type="checkbox"/> YES <input type="checkbox"/> NO                                       | (VAN, TANK, FLAT, DUMP, REFER) |            |          |                                 |
| MOTORCOACH - SCHOOL BUS _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <small>More than 8 passengers</small>  | —                              |            |          |                                 |
| MOTORCOACH - SCHOOL BUS _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <small>More than 15 passengers</small> | —                              |            |          |                                 |
| OTHER _____                                                                                                                   |                                |            |          |                                 |

LIST STATES OPERATED IN FOR LAST FIVE YEARS: \_\_\_\_\_

SHOW SPECIAL COURSES OR TRAINING THAT WILL HELP YOU AS A DRIVER: \_\_\_\_\_

WHICH SAFE DRIVING AWARDS DO YOU HOLD AND FROM WHOM? \_\_\_\_\_

**EXPERIENCE AND QUALIFICATIONS – OTHER**

SHOW ANY TRUCKING, TRANSPORTATION OR OTHER EXPERIENCE THAT MAY HELP IN YOUR WORK FOR THIS COMPANY

\_\_\_\_\_

LIST COURSES AND TRAINING OTHER THAN SHOWN ELSEWHERE IN THIS APPLICATION

\_\_\_\_\_

LIST SPECIAL EQUIPMENT OR TECHNICAL MATERIALS YOU CAN WORK WITH (OTHER THAN THOSE ALREADY SHOWN)

\_\_\_\_\_

**EDUCATION**

CIRCLE HIGHEST GRADE COMPLETED: 1 2 3 4 5 6 7 8 HIGH SCHOOL: 1 2 3 4 COLLEGE: 1 2 3 4

LAST SCHOOL ATTENDED \_\_\_\_\_(NAME) \_\_\_\_\_(CITY, STATE)

**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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_