

DOT APPLICATION FOR EMPLOYMENT

(Please Print)

Position Desired _____ Date _____

How did you learn about us?

Advertisement Friend Walk-In Relative Other _____

Name (Last) _____ (First) _____ (Middle) _____

Address _____ City _____ State _____ Zip _____

Telephone Number(s) _____ Social Security Number _____

Are you over 18 years of age? Yes No

If you are under 18 years of age, can you provide proof of your eligibility to work?
 Yes No

Have you ever filed an application with us before? Yes No

Are you physically or otherwise unable to perform the duties of the job for which you are applying?
 Yes No

If yes, please describe _____

Are you currently employed? Yes No

May we contact your present employer? Yes No

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status?
 Yes No

Proof of citizenship or immigration status will be required upon employment.

On what date would you be available for work? _____

Availability: Full Time Part Time Shift Work Temporary

Can you travel if a job requires it? Yes No

Have you ever been convicted or pled guilty or no contest to a felony offense?
 Yes No*

If yes, please explain.

For purposes of employment with New Distributing Co., Inc. "convictions" include sentenced to confinement, paid fine, time served, placed on probation (including deferred adjudication) and court-ordered restitution.

City/State _____ Charge _____

Please explain _____

*Conviction of a felony will not necessarily bar you from employment.

FELONY CONVICTION

I _____ agree to immediately notify New Distributing Co., Inc. if I am convicted of, receive deferred adjudication in, or otherwise plead guilty or no contest to a felony, or any crime involving dishonesty or a breach of trust, while my application is pending or during my period of employment, if hired.

Signature of Applicant

Date

EMPLOYMENT HISTORY FOR LAST TEN (10) YEARS

Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations which indicate race, color, religion, national origin, handicap or other protected status. If applicant is too young to have an employment history going back ten (10) years, include schools attended or whatever applicant was doing.

CURRENT OR MOST RECENT EMPLOYER:

Name _____ Phone _____

Address _____

Positions/Duties: _____

DATES EMPLOYED	
From	To
HOURLY RATE/SALARY	
Beginning	Ending

Supervisor: _____

Reason for leaving _____

Were you subject to U.S. Department of Transportation's alcohol and controlled substances testing requirements and the Federal Motor Carriers Safety Regulations for this job listed? Yes No

NEXT PREVIOUS EMPLOYER:

Name _____ Phone _____

Address _____

Positions/Duties: _____

DATES EMPLOYED	
From	To
HOURLY RATE/SALARY	
Beginning	Ending

Supervisor: _____

Reason for leaving _____

Were you subject to U.S. Department of Transportation's alcohol and controlled substances testing requirements and the Federal Motor Carriers Safety Regulations for this job listed? Yes No

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Name _____ Phone _____

Address _____

Positions/Duties: _____

Supervisor: _____

DATES EMPLOYED	
From	To
HOURLY RATE/SALARY	
Beginning	Ending

Reason for leaving _____

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Address _____

Positions/Duties: _____

Supervisor: _____

DATES EMPLOYED	
From	To
HOURLY RATE/SALARY	
Beginning	Ending

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Address _____

Positions/Duties: _____

Supervisor: _____

DATES EMPLOYED	
From	To
HOURLY RATE/SALARY	
Beginning	Ending

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Address _____

Positions/Duties: _____

DATES EMPLOYED	
From	To
HOURLY RATE/SALARY	
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Address _____

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From	To
HOURLY RATE/SALARY	
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Address _____

Positions/Duties: _____

DATES EMPLOYED	
From	To
HOURLY RATE/SALARY	
Beginning	Ending

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Reason for leaving _____

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Name _____ Phone _____

Address _____

Positions/Duties: _____

Supervisor: _____

DATES EMPLOYED	
From	To
HOURLY RATE/SALARY	
Beginning	Ending

Reason for leaving _____

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ACCIDENT RECORD AND TRAFFIC CONVICTIONS

Include vehicles having a GVWR of 26,001 lbs. or more, vehicles designed to transport 15 or more passengers, or any size vehicle 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	Type of Vehicle	Nature of Accident (Head-on, rear-end, upset, etc.)	Fatalities	Injuries
Last Accident				
Next Previous				
Next Previous				

List all violations of motor vehicle laws or ordinances (other than parking violations) of which you were convicted, forfeited bond, or collateral during the past three (3) years.

Location	Date	Charge	Penalty

(attach sheet if more space is needed)

Experience and Qualifications - Driver

	State	License No.	Type	Expiration Date
Driver				
Licenses				

- 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

Include a detailed explanation of the facts and circumstances for each denial, revocation or suspension.

Driving Experience if none, write none

Class of Equipment	Type of Equipment (van, tank, flat, etc.)	Dates		Approx. No. of Miles (Total)
		From	To	
Straight Truck				
Tractor & Semi-Trailer				
Tractor - Two Trailers				
Motorcoach - school bus				
Other				

List states operated in for last five years. _____

Driving Experience (cont.)

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 those shown elsewhere in this application.

List special equipment or technical materials you can work with (other than those already shown).

Drug Testing

Have you ever tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which you have applied for, but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol testing rules during the past two years?

Yes No

If yes, please give details: _____

YOUR RIGHTS REGARDING SAFETY PERFORMANCE HISTORY INFORMATION

The information you provided on this application may be used, and the applicant's prior employers may be contacted, for the purpose of investigating the applicant's safety performance history information. Pursuant to Federal Motor Carrier Safety Regulations 49 CFR Sec. 391.23 (i)(1) you have the following rights with regard to the safety performance history information provided by your previous employers.

THE RIGHT TO REVIEW SAFETY PERFORMANCE RECORDS

You have the right to review the records provided by your previous employers. You must make your request to review in writing and submit it to your prospective employer no later than thirty (30) days after employment begins or notification of employment is made. You will be provided with the records at the time of your request, then the five (5) day period to provide access will begin on the day the records are received from the previous employer. If you fail to arrange to pick up or receive the requested records within thirty (30) days of when they are first made available to you, then your right to review is considered waived.

THE RIGHT TO HAVE ERRONEOUS INFORMATION CORRECTED

If you believe there is an error in the records, you have the right to have your previous employer correct the error. Send your request for correction to the previous employer that provided the records in question. The previous employer must either correct and forward the record to the prospective employer or notify you within fifteen (15) days of receiving your request that they do not agree the record is in error. If the previous employer corrects and forwards the record as requested, that employer must also retain the corrected information as part of your safety performances history record and provide it to subsequent prospective employers when requests for this information are received.

THE RIGHT TO REBUT DISPUTED INFORMATION

If the previous employer does not agree that information in the records provided is in error, you may rebut the disputed information in writing and send it to the previous employer with instructions to include the rebuttal in your safety performance history file. Within five (5) business days of receiving your rebuttal, the previous employer must; forward a copy of the rebuttal to the prospective employer; append the rebuttal to your safety performance information and include it as part of the response for any subsequent investigating prospective employers for the duration of the three (3) year data retention requirement period. You may submit a rebuttal initially without a request for correction, or subsequent to a request for correction.

THE RIGHT TO REPORT FAILURES TO CORRECT ERRONEOUS INFORMATION

You may report failures of a previous employer to correct information or include your rebuttal as part of the safety performance, to the Federal Motor Carrier Safety Administration by following procedures specified at 49 CFR Section 385.12.

Date

Social Security Number

Employee Signature

Print Name

Signature of Employer's Representative

**DISCLOSURE TO EMPLOYMENT APPLICANT
REGARDING PROCUREMENT OF A CONSUMER REPORT**

In connection with your application for employment, we may procure a consumer report on you as part of the process of considering your candidacy as an employee. In the event that information from the report is utilized in whole or in part in making an adverse decision with regard to your potential employment, before making the adverse decision, we will provide you with a copy of the consumer report and a description in writing of your rights under the law.

Please be advised that we may also obtain an investigative report including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the information requested.

Such disclosure will be made to you within 5 days of the date on which we receive the request from you or within 5 days of the time the report was first requested.

The Fair Credit Reporting Act gives you specific rights in dealing with consumer reporting agencies. You will find these rights summarized on a separate document.

By your signature below, you hereby authorize us to obtain a consumer report about you in order to consider you for employment.

This report will be processed by: (name and address of agency running consumer report)

Applicant's Name (Please Print)

Applicant's Address

City/State/Zip

Social Security Number

Signature of Applicant

This page contains sensitive information. Keep only in secure files, separately from personnel files!

BACKGROUND INQUIRY RELEASE

In connection with my application for employment (including contract for services) with the above named Company or individual, I understand that an investigative consumer report may be requested that will include information as to my character, work habits performance and experience along with reasons for termination of past employment. I understand that as directed by company policy and consistent with the job described, you will be requesting information from public and private sources about my workers' compensation inquires, driving record, court record, education, credentials, credit and references.

Medical and workers' compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws. According to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my prospective employer from a consumer reporting agency. If so, I will be notified and given the names and address of the agency of the source which provided the information.

I acknowledge that a telephonic facsimile (Fax) or photographic copy shall be valid as the original. This release is valid for most federal, state and county agencies.

I hereby authorize, without reservation, any law enforcement agency, institution, service bureau, school, employer, reference or insurance company contacted by New Distributing Co., Inc. and/or its agents, to furnish the information described in the first paragraph.

I understand that the following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

Please print clearly all information.

Last Name: _____ First Name: _____ Middle: _____

Print other names you have used (including maiden name or previous married name(s) – or any other first name): _____

Social Security Number: _____ Date of Birth: _____ Sex: _____ Race: _____

Driver's License Number: _____ State where licensed was issued: _____

Name as it appears on driver's license: _____

Current Address: _____

City, State, Zip (County if known): _____

Applicant Signature

Date

List all previous addresses for the last seven (7) years.
Address, city, state, zip code and county if known and the length of time at each address.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

DRUG/ALCOHOL TEST

I understand and agree that the management of New Distributing Co., Inc. may request that I submit to drug/alcohol testing for illegal drugs/alcohol. Such a test will be conducted by New Distributing Co., Inc. on the Company premises and/or a recognized testing company that normally conducts such testing as a usual business activity.

I understand that the results of such a drug/alcohol test will not be revealed to anyone except management of New Distributing Co., Inc.

I understand that New Distributing Co., Inc. may request a drug test for illegal drugs *prior* to offering me employment with New Distributing Co., Inc. I understand that I will no longer be a candidate for hire if I fail to receive an acceptable result from the pre-employment drug test conducted for me or for failure to submit to the requested pre-employment test.

I understand that after I am employed by New Distributing Co., Inc. I may be discharged for failing to receive an acceptable result from any drug/alcohol test conducted for me or for failure to submit to a requested test. I understand that the Company requests such information as a part of its continuing effort to maintain the highest quality safe work environment.

I have read and understood the above.

Date

Social Security Number

Employee Signature

Print Name

Signature of Employer's Representative

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: New Distributing Co., Inc. has workers' compensation insurance coverage from Federated Insurance Company protect you in the event of work-related injury or illness. This coverage is effective from April 1, 2007. Any injuries or illnesses which occur on or after that will be handled by Federated Insurance Company. An employee or a person acting on the employee's behalf must notify the employer of an injury or illness not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an illness, unless the Division determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will explain your rights and responsibilities under the Workers' Compensation Act and assist in resolving disputes about a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031.

SAFETY HOTLINE: The Division has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employer are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Health and Safety at 1-800-452-9595.

"You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained coverage, you notify your employer in writing that you wish to retain your common law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."

I have read and understood the above

AVISO SOBRE COMPENSACION PARA TRABAJADORES EN TEXAS

COBERTURA: New Distributing Co., Inc. tiene aseguranza para compensar al trabajador con Federated Insurance Company nombre de la compañía de seguros para protegerlo en el caso de una lesión o enfermedad relacionada con su trabajo. Esta aseguranza está vigente desde April 1, 2007. Cualquier lesión o enfermedad que ocurra en o a partir de esa fecha sera manejada por la Federated Insurance Company. El trabajador o la persona que lo representa debe notificar al patrón cuando ocurra una lesión o enfermedad antes de treinta (30) días después de que ocurra la lesión o dentro de treinta (30) días de la fecha en que el empleado se entero o debería estar enterado de la enfermedad, salvo que la División determine que existía un buen motivo para no haber notificado al patrón dentro del tiempo señalado. Su patrón está obligado a proporcionarle información sobre la aseguranza, por escrito, cuando lo contrate para trabajar y así mismo debe de informarle cuando obtenga o deje de tener seguro de compensación para el trabajador.

ASISTENCIA AL EMPLEADO: La División le proporcionará información gratuita sobre como someter un reclamo de compensación para el trabajador. El personal de la División le explicará cuales son sus derechos y responsabilidades bajo la Ley de Compensación para el Trabajador y le asistirá para resolver cualquier controversia que surja al hacer su reclamo. Usted puede obtener esta ayuda comunicandose con la oficina local de la División o llamando al número 1-800-252-7031.

LINEA PARA REPORTAR CONDICIONES INSEGURAS: La División ha establecido una línea telefónica gratuita las 24 horas del día, para reportar condiciones inseguras en el lugar de trabajo que pudiera violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los patrones suspendan, despidan o descriminen al empleado o empleada porque él o ella, de buena fe; reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la Sección de Salud y Seguridad Laboral al número 1-800-452-9595.

"Puede elegir a retener su derecho de la ley comun de acción si, que no pase de cinco dias despues que usted empieze el empleo o dentro de cinco dias despues de recibir noticia escrita del empleador que el empleador ha sido cubierto, usted notifique a su empleador por escrito que usted desea retener su derecho de la ley comun para retener danos por lastimación personal. Si usted elije retener su derecho de la ley comun de acción, usted no puede obtener un salario de compensacion para los trabajadores o beneficios medicos si usted es lastimado "

Yo he leído y entiendo esta notificación.

Date (Fecha)

Social Security Number (Número de seguro social)

Employee Signature (Firma del Empleado)

Print Name (Nombre en letra de molde)

Signature of Employer's Representative (Firma del Representante del Empleador)

WORK RELATED INJURIES

I understand that I must notify my supervisor at no later than the end of my work shift if I am injured on the job. Non-compliance of this policy is cause for termination.

MEDICAL RELEASE OF INFORMATION AUTHORIZATION

All medical information is strictly confidential; however, I, _____, authorize the Physician, and/or any health care provider/facility to release/disclose all information concerning my WORK-RELATED condition/treatment to New Distributing Co., Inc. for the purposes of case management and coordination of my care, and any party that is or may be liable for all or part of the medical charges, or to determine benefits entitlements for any work-related injury of disease incurred while employed by New Distributing Co., Inc.

I hereby release the above-mentioned parties from any liability arising from such disclosure. A reproduction of this authorization shall be valid as the original for the duration of my employment with New Distributing Co., Inc.

I have read and understood the above.

Date

Social Security Number

Employee Signature

Print Name

Signature of Employer's Representative

Dear Health Care Provider: If you believe it is necessary to restrict the employee from returning to work, please call our Director of Personnel at _____.

WAGE DEDUCTION AUTHORIZATION AGREEMENT

I understand and agree that my employer, **New Distributing Co., Inc.** (the Company), may deduct money from my pay for reasons that fall into the following categories:

1. My share of the premiums for the Company's group medical/dental plan;
2. Any contributions I may make into a retirement or pension plan sponsored, controlled, or managed by the Company, if any;
3. Installment payments on loans, store credit, or wage advances given to me by the Company, including the value of merchandise that I purchase or have purchased on my employee charge account, and if there is a balance remaining when I leave the Company, the balance of such loans, store credit, or advances;
4. If I receive an overpayment of wages for any reason, repayment to the Company of such overpayments;
5. The cost to the Company of personal long-distance calls I may make on Company phones or on Company accounts, of personal faxes sent by me using Company equipment or Company accounts, or of non-work related access to the Internet or other computer networks by me using Company equipment or Company accounts;
6. The cost of repairing or replacing any Company supplies, materials, equipment, money, or other property that I may damage (other than normal wear and tear), lose, fail to return, or take without appropriate authorization from the Company during my employment (specifically including, but not limited to, company issued laptop computers, cell phones and other tools and equipment);
7. The cost of Company uniforms and of cleaning the uniforms as long as it does not take me below the applicable minimum wage;
8. The reasonable cost or fair value, whichever is less, of meals, lodging, and other facilities furnished to me by the Company in connection with my employment;
9. Administrative fees in connection with court-ordered garnishments or legally required wage attachments of my pay, limited in extent to the amount or amounts allowed under applicable laws;
10. If I take paid vacation or sick leave in advance of the date I would normally be entitled to it and I separate from the Company before accruing time to cover such advance leave, the value of such leave taken in advance that is not so covered;
11. The value of any time off for absences to which paid leave is not applied (non-exempt salaried employees will have all such unpaid leave deducted from their salary, while exempt salaried employees will experience salary reductions only in units of a full day at a time);
12. If my employer pays any insurance premiums or retirement system contributions ("payments") on my behalf that I would normally make under the applicable Company benefit plan, the amount of such payments made by the Company, such payments being an advance of future wages payable to me; and I agree that the Company may deduct money from my pay under the above circumstances, or if any of the above situations occur.

Date

Social Security Number

Employee Signature

Print Name

Signature of Employer's Representative

The following section pertains to applicant drivers only:

Have you tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which you have applied for, but did not obtain, safety-sensitive transportation work covered by any DOT agency drug and alcohol testing rules during the past 3 years? No _____ Yes _____

Date

Driver's Signature

Date

Witness' Signature

The Company is required to maintain the original of the signed Certificate but may provide a copy to the driver.

APPLICANT'S CERTIFICATION AND AGREEMENT

I certify 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. I also certify that I have accounted correctly for my work experience, education and training.

This application for employment shall be considered active for a period of time not to exceed one hundred eighty (180) days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are accepted at that time.

I understand that misrepresentation or omission of facts will be cause for cancellation of my consideration for employment, or dismissal, if employed. I authorize the Company and/or its agents, including consumer and/or credit reporting bureaus, to verify any information contained in this Hiring Packet including, but not limited to, criminal history and motor vehicle driving records (if driving is an essential function of the job). I authorize all persons, schools, companies, and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I further understand and agree that employment by this Company will be "at will." That is, either I or the Company may end the employment relationship at any time for any reason or for no reason. Also, I understand that no representative of the Company has the authority to enter into any agreement with me for employment for any specific period of time or make any agreement with me contrary to the foregoing.

I further certify that I have no objections to the following conditions concerning my employment:

1. Submitting to a medical review and an examination by a medical professional chosen by the Company after a conditional job offer has been made and before reporting for work, as determined by the essential functions of the job and Company policy.
2. Taking a physical agility test if required by the essential functions of a specific position.
3. Submitting to a drug/alcohol examination when requested by the Company as stated in the Company Drug/Alcohol Testing Policy.
4. Demonstrating the skill and ability to perform the essential functions of the assigned job.
5. Available for overtime.
6. Returning all Company issued items at the time of termination.
7. Abiding by the rules and regulations of the Company.
8. Available to work at the prevailing rate at that time, if assigned to another shift, department, or job.
9. Submitting to a security search when requested by the Company.

Date

Social Security Number

Employee Signature

Print Name

Signature of Employer's Representative