







**SHOW ALL EMPLOYMENT HISTORY FOR THE PAST 10 YEARS**

Begin with your present experience and work backward in order, listing all employers, military service, self-employment, driving school, and other training programs for at least 10 years. Use a supplementary sheet if necessary. Leave NO gaps in time for past 10 years. All time must be accounted for. We must have complete addresses and telephone numbers (please include fax numbers if available).

Employment Dates _____ to _____	Position Held: _____
Company: _____	Phone: (_____) _____
Address: _____	Fax: (_____) _____
Reason for leaving? _____	
Number of accidents? _____ Comments: _____	

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Address: _____	Fax: (_____) _____
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Company: _____	Phone: (_____) _____
Address: _____	Fax: (_____) _____
Reason for leaving? _____	
Number of accidents? _____ Comments: _____	

\*\*Ten years are accounted for and there are no gaps between any of the above dates. [ ] Yes [ ] No  
If answered 'No,' please explain: \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

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If answered 'No,' please explain: \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**SAFETY PERFORMANCE HISTORY INQUIRY**  
(PLEASE PRINT)

Applicant's Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

I hereby authorize and request the company below to release ALCOHOL and CONTROLLED SUBSTANCES information as listed in 49 CFR Section 40.25(b) to Kelworth Trucking Company. My previous employer will be released from any and all liability, which may result from releasing such information.

\_\_\_\_\_  
Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Witness

**Prior Employer:**

Company Name _____		DBA _____		
Address _____		_____		
Street	City	State	Zip	
Phone (_____) _____	Fax (_____) _____	Attention _____		

**Required information from Section 382.413 and 40.25(b)**

1. Has this person ever tested positive for controlled substances in the past three years during employment with your company? [ ] Yes [ ] No
  
2. Has this person ever had a breath alcohol test result .04 or greater in the past three years during employment with your company? [ ] Yes [ ] No
  
3. Has this person ever refused a required test, including a verified adulterated substituted result, for drugs or alcohol testing in the past three years with your company? [ ] Yes [ ] No
  
4. Have you received any information from prior employers regarding violations of drug/alcohol testing regulations? [ ] Yes [ ] No
  
5. Any other violations of DOT agency drug and alcohol testing regulations including not hiring due to pre-employment positive results? [ ] Yes [ ] No
  
6. Any documentation of the employee's DOT return to duty qualification? [ ] Yes [ ] No

With reference to question number 6, please identify the Substance Abuse Professional you referred the driver to if he/she tested positive or refused testing.

Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State

Completed by: \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:** Failure to furnish information as required by 49 CFR 382.413 and 40.25 will result in the above named individual being removed from any CDL driving position. You are required to release this information immediately per 49 CFR 382.405(f) and 40.25(h). Fines and penalties for not releasing this information are found in 49 CFR 382.507 under 49 USC 521(b). We reserve the right to notify the US DOT Federal Motor Carrier Safety Administration in the event the above information is not received.

**Please fax this form back to (918) 647-9602**

Company Name: \_\_\_\_\_ Attn: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

The person listed above has applied for a position with Kelworth Trucking Company as an OTR driver. Pursuant to sections 391, 382, 40 and other DOT regulations, please provide the following information.

Dates of employment: \_\_\_\_\_ to \_\_\_\_\_ Type of equipment driven: \_\_\_\_\_

Type of freight: \_\_\_\_\_ States / Area driven: \_\_\_\_\_

Company Driver  Owner Operator  Driver for Owner Operator

Voluntary quit  Terminated Why? \_\_\_\_\_

Is this individual eligible for rehire?  Yes  No

If 'No,' please explain \_\_\_\_\_

- 1. Has the above mentioned individual had any out-of-service for hours of service violations in the past 12 months?  Yes  No
- 2. Has the above mentioned individual had any DOT recordable accidents as defined in 390.5?  Yes  No
- 3. Has the above mentioned individual had any accidents pursuant to your internal policies for minor accidents? If so, please supply information.  Yes  No

Accidents in the past three (3) years. If none, state NONE. (Attach separate sheet if necessary)

Date	Type / Nature of Accident / Description Example: Head-on, Rear-end, Overturn	Tow	EMS	Location: Street / Hwy City / State

Cargo loss \_\_\_\_\_ Equipment loss \_\_\_\_\_

I hereby authorize my previous employer to release all records related to my employment, job performance, safety related situations or accidents. I hereby release the above listed employer from any and all liability of any type occurring as a result of providing the above information. I have been offered an opportunity to ask any questions and to have those questions answered to my satisfaction. I have executed this release voluntarily and understand the information being released could affect my being hired.

\_\_\_\_\_  
Applicant's Signature Date

\_\_\_\_\_  
Information Supplied by Date

Received by:  Fax  Phone  Mail

\_\_\_\_\_  
Sender Date

Date faxed, phoned, or mailed: \_\_\_\_\_

**Please fax this form back to (918) 647-9602**



**Authorization for Release of Information  
Regarding Claimants Seeking Worker's Compensation Benefits**

I, \_\_\_\_\_, having filed a claim with worker's compensation benefits, do hereby waive any physician/patient, or chiropractor/patient privilege I may have. I also hereby authorize any health care provider to furnish to my employer, its worker's compensation carrier, or its agent any information or written material reasonably related to my work-related injury and any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other condition related to the same body part.

Such information is being disclosed to the purpose of facilitating my claim for worker's compensation benefits.

I understand that failure to sign this medical waiver may result in suspension or delay of the worker's compensation claim.

I understand that the information used or disclosed pursuant to the medical waiver may be subject to re-disclosure by the recipient.

A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-ray reports, Cat-scans, MRIs, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness Signature

**Worker's Compensation and HIPAA**

On April 14, 2003, the federal Health Insurance and Accountability Act (HIPAA) privacy regulation took effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosure for worker's compensation is in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to worker's compensation..."

## Declaration of Employment Status

Under the Federal Motor Carriers Safety Regulations (Section 391.23), Kelworth Trucking Company is required to verify the employment background of all prospective drivers for the proceeding three (3) years / ten (10) of all CDL driving experience. This form enables you to account for any period of time that you have advised us that you were unemployed or self-employed which cannot be verified by other means. In the section below, please fill in the date and describe your activities during that time.

DATES:

\_\_\_\_\_ to \_\_\_\_\_  
Month/Year Month/Year

During the period specified, I was engaged as follows:

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I also confirm that during that period, the statements I have checked are true:

- I was not employed in any capacity on a full-time basis or a regular part-time basis.
- I was self-employed.
- I did not collect unemployment during that period.
- I was not convicted of a crime or felony involving a motor carrier or any aspect carrier industry.

**Please list two (2) people who can verify the above information; neither whom are related to you in any manner.**

\_\_\_\_\_  
Name Address Telephone Number

\_\_\_\_\_  
Name Address Telephone Number

I hereby authorize Kelworth Trucking Company to contact the persons listed above and authorize them to release the requested information to Kelworth Trucking Company.

\_\_\_\_\_  
Applicant's Name Signature Date



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Applicant's Name	Address	City/State/Zip	Telephone Number
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**Personal References:**

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Name	Address	City/State/Zip	Telephone Number
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Name	Address	City/State/Zip	Telephone Number
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Name	Address	City/State/Zip	Telephone Number
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**In case of emergency, contact:**

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Name	Relationship	Telephone Number
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Name	Relationship	Telephone Number
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