

EMPLOYMENT APPLICATION
DRIVER

APPLICATION FOR EMPLOYMENT

PRE-EMPLOYMENT QUESTIONNAIRE EQUAL OPPORTUNITY EMPLOYER

This application will only be considered "active" for 90 calendar days from the date of application. If the applicant has not obtained Employment within the 90 calendar days, a new application must be submitted. Quality Labor Management, LLC is an Equal Opportunity Employer.

PERSONAL INFORMATION

NAME (LAST, FIRST)		SOCIAL SECURITY NO.		
PRESENT ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NO. ()
DRIVERS LICENSE NUMBER		CELL NUMBER ()		
EMAIL ADDRESS		CELL PHONE CARRIER		
EMERGENCY CONTACT		PHONE NO. ()		

ETHNIC BACKGROUND (OPTIONAL)

CAUCASIAN NATIVE AMERICAN ASIAN
 AFRICAN AMERICAN LATINO OTHER _____

HAVE YOU EVERY BEEN CONVICTED OF A CRIME? YES / NO (IF YES) LIST OFFENSE AND DISPOSTION OF THE CASE:	
NOTE: A CONVICTION MAY NOT AUTOMATICALLY DISQUALIFY YOU FROM EMPLOYMENT. THE DATE AND SERIOUSNESS OF THE CRIME WILL BE TAKEN INTO CONSIDERATION.	IF HIRED, ALL EMPLOYEES MUST IMMEDIATELY NOTIFY THEIR SUPERVISOR IN WRITING OF ANY CONVICTION OR RECORD OF ADJUDICATION BEING WITHHELD ARISING AFTER HIRE. FAILURE TO ABIDE BY THIS PROCEDURE IS A TERMINABLE OFFENSE

HAVE YOU EVER BEEN EMPLOYED BY Quality Labor Management, LLC BEFORE? YES NO

BRANCH	DATES FROM: TO:	REASON FOR LEAVING:
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DRUG-FREE ENVIRONMENT POLICY AND DRUG TESTING

QLM maintains a Drug-Free Environment. As a result, we reserve the right to require any applicant or employee to take a drug test at anytime. If you use illegal drugs do not apply! We also reserve the right to search any package or vehicle brought on to our property to assure compliance with our policies and procedures.

I, _____, voluntarily hereby agree, that if I am
PRINT NAME (FIRST) (LAST)
injured while employed by Quality Labor Management, LLC, I will submit to an alcohol blood test and a urinalysis sample to determine if I have a controlled substance presence, resulting in medical treatment necessitated for my injury, and that if I refuse and/or fail either or both of these tests, I will absolve Quality Labor Management, LLC, from any responsibility regarding my injury. I also understand that Quality Labor Management, LLC maintains a *Drug-Free Workplace Environment* and that the consequences for violating this policy will include termination of employment for cause and denial of Workers' Compensation Benefits and Unemployment Compensation. Failure to immediately report a work-related accident/injury to the dispatching Quality Labor Management, LLC's, office, will constitute a refusal to submit to drug/alcohol testing under the Quality Labor Management, LLC's, Drug Free Environment Policy.

UNEMPLOYMENT BENEFITS

With my signature below, I hereby understand, agree and acknowledge as follows, that Section 6366 of the Adjudication Manual of the Florida Department of Labor and Unemployment Security, has determined that I will be deemed to have voluntarily quit employment of Quality Labor Management, LLC for reassignment; provided that, I am hereby notified, at the time of hire. This section is intended to provide me notification of the expectations that I must return for reassignment. If I do not return to Quality Labor Management, LLC's office, I will have been deemed to voluntarily resign. Laws in other states may vary.

- 1. The undersigned must report in person for reassignment upon conclusion of each daily and/ or weekly assignment, and unemployment benefits may be denied for failure to do so.**

AUTHORIZATION

"I certify that the facts contained in this application are complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for termination. I authorize investigation of all statements contained herein and release the company from liability for any damage that may result from utilization of such information."

 SIGNATURE: _____

DATE: _____

WITNESS: _____

BRANCH: _____

(Quality Labor Management, LLC)

DRIVER'S APPLICATION FOR EMPLOYMENT

Applicant Name _____ Date of Application _____

Company _____

Address _____

City _____ State _____ Zip _____

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 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 _____

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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National Background Screening Consent/Release Form

Applicant's **Legal** Name (printed)

Social Security Number _____ Date of Birth _____

Driver License Number _____

Applicant's Address

City _____ State _____ Zip _____

I, _____, authorize and give consent for the above named organization to obtain information regarding myself. This includes the following:

- Local & National Criminal background records/information
- MVR
- All 50 State Sex Offender Registries
- Full Address Trace
- Social Security Verification

I the undersigned, authorize this information to be obtained either in writing or via telephone in connection with my application. Any person, firm or organization providing information or records in accordance with this authorization is released from any and all claims of liability for compliance. Such information will be held in confidence in accordance with the organization's guidelines.

Print Name: _____ Date: _____

Signature: _____

MEDICAL HISTORY QUESTIONNAIRE

For applicants who have received Conditional Job Offers. The statement as found on this section of this page must be signed by the applicant before completing the following Medical Questionnaire

The purpose of this inquiry is to determine whether I currently have the physical or mental qualifications necessary to perform the job that has been offered, whether and what accommodations may be necessary. and whether I can perform the job without posing a direct threat to the health of safety of myself or others and for the purposes and reasons stated on the below questionnaire.

SIGNATURE: _____ **DATE:** _____

Do you have or have you had any of the following? Please check each box individually.

Yes No

- | | | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, Convulsions, Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis or Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes / Hyperinsulinism | <input type="checkbox"/> | <input type="checkbox"/> | Back / Neck Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac (Heart Disease) / Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Total loss of sight of one or both eyes or
A partial loss of corrected vision of more than 75% Bilaterally. | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any broken bones? | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever sprained or strained a muscle? | <input type="checkbox"/> | <input type="checkbox"/> | Severe Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Deafness _____% Impairment | <input type="checkbox"/> | <input type="checkbox"/> | Knee or Ankle Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Breathing Difficulty | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies. If yes, what type? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Mental illness, Psychiatric Treatment
or Professional Counseling | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or Fainting Spells | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Head Injury | | | | | |

Are you on any medications? If so, what kinds? _____

Answer Yes or No to the following with explanations where necessary.

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you previously filed a workers' compensation claim whether or not you have received any benefits for the on-the-job injury? If yes, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever received a disability rating as a result of a workers' compensation injury? If yes, list percentage: _____ % |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured or sprained your shoulder? If yes, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured or sprained a knee? If yes, please explain indicating if surgery was required: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever injured or sprained your back/neck? If yes, please explain indicating if surgery was required? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any type of surgery? If yes, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you receiving any disability compensation from Social Security or Military for any disability? _____ |

Under penalty of perjury and termination, I have read the foregoing, I have been given the opportunity to ask for any clarification / needed, and I certify that the answers I have given are true and correct to the best of my knowledge.

SIGNATURE: _____ **DATE:** _____

SKILLS & TRAINING

Please list areas in which you have specific job experience and training:

Email Address

- | | |
|--|--|
| <input type="checkbox"/> Electrician
<input type="checkbox"/> Apprentice
<input type="checkbox"/> Journeyman
<input type="checkbox"/> Electrical Helper

<input type="checkbox"/> Carpentry
<input type="checkbox"/> Form Carpenter
<input type="checkbox"/> Trim/Finish Carpenter
<input type="checkbox"/> Frame Carpenter
<input type="checkbox"/> Carpenter Helper

<input type="checkbox"/> Sheet Metal
<input type="checkbox"/> A/C Duct Mechanic
<input type="checkbox"/> A/C Duct Helper

<input type="checkbox"/> Masonry
<input type="checkbox"/> Block
<input type="checkbox"/> Brick
<input type="checkbox"/> Tender

<input type="checkbox"/> Plumbing
<input type="checkbox"/> Pipefitter
<input type="checkbox"/> Pipefitter/Welder
<input type="checkbox"/> Plumber's Helper
<input type="checkbox"/> Copper Plumber
<input type="checkbox"/> Apprentice Plumber
<input type="checkbox"/> Journeyman Plumber
<input type="checkbox"/> Master Plumber

<input type="checkbox"/> Iron Worker

<input type="checkbox"/> General Labor

<input type="checkbox"/> Drywall
<input type="checkbox"/> Drywall Hanger
<input type="checkbox"/> Drywall Finisher
<input type="checkbox"/> Drywall Framers | <input type="checkbox"/> Welding
<input type="checkbox"/> Mig
<input type="checkbox"/> Tig
<input type="checkbox"/> Stick
<input type="checkbox"/> Stainless Steel
<input type="checkbox"/> Aluminum
<input type="checkbox"/> Certified

<input type="checkbox"/> Heavy Equipment
<input type="checkbox"/> Bulldozer
<input type="checkbox"/> Front End Loader
<input type="checkbox"/> Crane
<input type="checkbox"/> Grader
<input type="checkbox"/> Hoist & Winch
<input type="checkbox"/> Pan
<input type="checkbox"/> Trencher

<input type="checkbox"/> Painting
<input type="checkbox"/> Prep Work
<input type="checkbox"/> Spray Gun
<input type="checkbox"/> Preservation

<input type="checkbox"/> Concrete
<input type="checkbox"/> Concrete Finisher
<input type="checkbox"/> Stage Forms
<input type="checkbox"/> Rodbuster

<input type="checkbox"/> Miscellaneous Construction
<input type="checkbox"/> Stucco
<input type="checkbox"/> Plasterer
<input type="checkbox"/> Helper

<input type="checkbox"/> Other Construction Trades:
_____ |
|--|--|

S

- | | | |
|--|---|---|
| <input type="checkbox"/> Industrial Machinery
<input type="checkbox"/> Brake Press
<input type="checkbox"/> Lathe
<input type="checkbox"/> Drill Press
<input type="checkbox"/> Industrial Saw
<input type="checkbox"/> Grinder
<input type="checkbox"/> Punch Press
<input type="checkbox"/> Power Press
<input type="checkbox"/> Industrial Screw Gun
<input type="checkbox"/> Injection Mold Machine | <input type="checkbox"/> Truck Driver
<input type="checkbox"/> CDL License
<input type="checkbox"/> Class A
<input type="checkbox"/> Class B
<input type="checkbox"/> Class C
<input type="checkbox"/> Class D
<input type="checkbox"/> Commercial
_____ # axles | <input type="checkbox"/> Fork Lift
<input type="checkbox"/> Electric
<input type="checkbox"/> Gas

<input type="checkbox"/> Machinist

<input type="checkbox"/> Training & Education:

_____ |
|--|---|---|

Name

- | | | |
|--|--|---|
| <input type="checkbox"/> Hotel Support
<input type="checkbox"/> Housekeeper
<input type="checkbox"/> Stewards
<input type="checkbox"/> Front Desk | <input type="checkbox"/> Valet Driver
<input type="checkbox"/> Banquet
<input type="checkbox"/> Maintenance
<input type="checkbox"/> Dishwasher | <input type="checkbox"/> Chef/Cook/Prep
<input type="checkbox"/> Laundry
<input type="checkbox"/> Bellmen |
|--|--|---|

Certifications/Licenses:

Please list any certifications/licenses you have: _____

Please list any skills/trades not listed above: _____

Do you have your own tools? _____

ANNUAL MOTOR VEHICLE DRIVER'S CERTIFICATION OF VIOLATIONS

In accordance with 49 CFR 391.27, I _____ certify that the following is a true and complete list of traffic violations (other than parking violations) for which I have been convicted or forfeited bond or collateral during the past 12 months.

Date	Offense	Location (City/State)	Type of Vehicle Operated

If no violations are listed above, I certify that I have not been convicted or forfeited bond or collateral on account of any violation required to be listed during the past 12 months.

(Date of Certification)

(Driver's Signature)

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ANNUAL REVIEW OF DRIVING RECORD

In accordance with 49 CFR 391.25, I certify that I have carefully reviewed the driving record of _____ to determine whether or not he/she meets the minimum requirements for safe driving specified in 49 CFR 391.11 or is disqualified to drive a motor vehicle pursuant to 49 CFR 391.15.

In reviewing this driver's record, I certify that I have considered any evidence that the driver has violated any applicable Federal Motor Carrier Safety Regulations or Hazardous Materials Regulations; and considered the driver's accident record and any evidence that the driver has violated laws governing the operations of motor vehicles, and I have given great weight to violations, such as speeding, reckless driving, and operating while under the influence of alcohol or drugs, that indicate that the driver has exhibited a disregard of the safety of the public.

A copy of the response from each State agency to the inquiry required by 49 CFR 391.25(b) is attached. This form shall be maintained in the driver's qualification file, as required by 49 CFR 391.51.

(Motor Carrier's Name)

(Review Date)

(Motor Carrier's Address)

(Reviewed By: Signature)

(Title)