



NAME \_\_\_\_\_ M or F  
(First) (Middle) (Last)

ADDRESS \_\_\_\_\_  
(Street) (City) (State) (Zip)

DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_ Terminal Code: \_\_\_\_\_

TELEPHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_ Email Address: \_\_\_\_\_

Have you ever been employed by this company in the past? Yes  No

If yes, please explain \_\_\_\_\_

Fair Credit Reporting Act Disclosure Statement

In accordance with the provision of Section 604(b)(2)(A) of the Fair Credit Reporting Act, Public Law 91-508, as amended by the Consumer Credit Reporting Act of 1996 (Title II, Subtitle D, Chapter I, of Public Law 104-208), you are being informed that reports verifying your previous employment, previous drug and alcohol test results, and your driving record may be obtained on you for employment purposes. These reports are required by Sections 382.413, 391.23, and 391.25 of the Federal Motor Carrier Safety Regulations.

Driver Notification

This notice serves to fulfill the requirements of 49 CFR Part 391.23(i). Each motor carrier must notify each driver, who is regulated by the Department of Transportation, of their rights regarding investigative information that will be provided to a prospective employer.

Drivers have:

- The right to review information provided by previous employers;
- The right to have errors in the information corrected by the previous employer and for that previous employer to re-send the corrected information to the prospective employer;
- The right to have a rebuttal statement attached to the alleged erroneous information, if the previous employer and the driver cannot agree on the accuracy of the information.

Past Pre-Employment Drug & Alcohol Testing Question

In accordance with 49 CFR Part 40.25(j) the employer is required to ask the employee:

Have you ever tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which the employee 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



**Applicant's Name** \_\_\_\_\_ **Terminal Code** \_\_\_\_\_

**PREVIOUS ADDRESSES FOR THE PAST 3 YEARS** (attach a separate sheet if more space is needed)

\_\_\_\_\_  
 (Street) (City) (State) (Zip)

\_\_\_\_\_  
 (Street) (City) (State) (Zip)

**CURRENT DRIVERS LICENSE**

\_\_\_\_\_  
 (State) (License No.) (Class/Type) (Expiration Date)

**DRIVER LICENSES FOR THE PAST 3 YEARS** (attach a separate sheet if more space is needed)

\_\_\_\_\_  
 (State) (License No.) (Class/Type) (Expiration Date)

\_\_\_\_\_  
 (State) (License No.) (Class/Type) (Expiration Date)

Have you ever had your license, permit or driving privileges suspended or revoked? Yes  No

If yes, please explain \_\_\_\_\_

**DRIVING EXPERIENCE** (attach a separate sheet if more space is needed)

Class A (Semi-Tractors): \_\_\_\_\_  
 (# of Years & Months Operated)

Types of Trailers Transported/Operated

Dry Van: <input type="checkbox"/>	Reefer: <input type="checkbox"/>	Flatbed: <input type="checkbox"/>	Double/Triples: <input type="checkbox"/>	Tanker: <input type="checkbox"/>
Pneumatic: <input type="checkbox"/>	Dump Trailer: <input type="checkbox"/>	Hopper: <input type="checkbox"/>	Intermodal: <input type="checkbox"/>	Auto Hauler: <input type="checkbox"/>
Specialized: <input type="checkbox"/>	Hot Shot: <input type="checkbox"/>	Other (please list): _____		

**MOTOR VEHICLE ACCIDENTS FOR PAST 3 YEARS** (attach a separate sheet if more space is needed)

Date	Description of the Accident	Towed Yes/No	# of Fatalities	# of Injuries

**VIOLATIONS OF MOTOR VEHICLE LAWS or ORDINANCES FOR THE PAST 3 YEARS**

(please do not list parking violations - attach a separate sheet if more space is needed)

_____ (Violation)	_____ (Date of Violation)	_____ (Violation)	_____ (Date of Violation)
_____ (Violation)	_____ (Date of Violation)	_____ (Violation)	_____ (Date of Violation)
_____ (Violation)	_____ (Date of Violation)	_____ (Violation)	_____ (Date of Violation)



**Applicant's Name** \_\_\_\_\_

Have you ever been convicted of a Felony? Yes  No

If yes, please explain \_\_\_\_\_

Have you ever been convicted of driving while intoxicated or under the influence of drugs or alcohol?

Yes  No  If yes, please explain \_\_\_\_\_

Have you failed any DOT required alcohol and/or drug testing within the past 5 years? Yes  No

If yes, please explain \_\_\_\_\_

Are currently working for any other employers, full time or part time? Yes  No

If No, please explain and how long? \_\_\_\_\_

**Past Employment or Lease Record** :( List ALL past employment for the last 10 years including DOT regulated, leased contracts and non DOT regulated)

**Past Employer/Leased Company** \_\_\_\_\_

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

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Position Held \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Reason for Leaving \_\_\_\_\_ CDL Class A? Yes NO

Was your job subject to DOT alcohol and drug testing as required by 49 CFR Part 40? Yes \_\_\_\_\_ No \_\_\_\_\_

Were you subject to the FMCSR's while employed/leased by this company? Yes \_\_\_\_\_ No \_\_\_\_\_

**Past Employer/Leased Company** \_\_\_\_\_

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

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Position Held \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Reason for Leaving \_\_\_\_\_ CDL Class A? Yes NO

Was your job subject to DOT alcohol and drug testing as required by 49 CFR Part 40? Yes \_\_\_\_\_ No \_\_\_\_\_

Were you subject to the FMCSR's while employed/leased by this company? Yes \_\_\_\_\_ No \_\_\_\_\_

**Past Employer/Leased Company** \_\_\_\_\_

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

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Position Held \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Reason for Leaving \_\_\_\_\_ CDL Class A? Yes NO

Was your job subject to DOT alcohol and drug testing as required by 49 CFR Part 40? Yes \_\_\_\_\_ No \_\_\_\_\_

Were you subject to the FMCSR's while employed by this employer? Yes \_\_\_\_\_ No \_\_\_\_\_

**Past Employer/Leased Company** \_\_\_\_\_

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

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Position Held \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Reason for Leaving \_\_\_\_\_ CDL Class A? Yes NO

Was your job subject to DOT alcohol and drug testing as required by 49 CFR Part 40? Yes \_\_\_\_\_ No \_\_\_\_\_

Were you subject to the FMCSR's while employed/leased by this company? Yes \_\_\_\_\_ No \_\_\_\_\_



**Applicant's Name** \_\_\_\_\_

**Past Employer/Leased Company** \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
 Position Held \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
 Reason for Leaving \_\_\_\_\_ CDL Class A? Yes NO  
 Was your job subject to DOT alcohol and drug testing as required by 49 CFR Part 40? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Were you subject to the FMCSR's while employed/leased by this company? Yes \_\_\_\_\_ No \_\_\_\_\_

**Past Employer/Leased Company** \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
 Position Held \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
 Reason for Leaving \_\_\_\_\_ CDL Class A? Yes NO  
 Was your job subject to DOT alcohol and drug testing as required by 49 CFR Part 40? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Were you subject to the FMCSR's while employed/leased by this company? Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\*If needed, please add additional past employers on a separate sheet**

**In Case of Emergency Please Contact:**

Name	Relationship	Telephone No.
------	--------------	---------------

**TO BE READ AND SIGNED BY THE APPLICANT**

This certifies that this application and any additional past employer records have been completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge. I understand that if employed or leased, any misstatement or omission of fact on this application shall be considered cause for dismissal. I authorize investigation of all statements contained in this application for employment or lease as may be necessary in arriving at a decision.

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

\_\_\_\_\_  
 Date of Application

Rehire Date \_\_\_\_\_

This certifies that this application and any additional past employer records have been completed by me, and that all entries on it and information in it are up to date and true and complete to the best of my knowledge. I understand that if employed or leased, any misstatement or omission of fact on this application shall be considered cause for dismissal. I authorize investigation of all statements contained in this application for employment or lease as may be necessary in arriving at a decision.

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

\_\_\_\_\_  
 Date of Application



**PAST EMPLOYMENT SAFETY HISTORY REQUEST**

FROM: The Evans Network of Companies, 100-110 W. Columbia St. Schuylkill Haven PA 17972

PHONE: 570-385-9048 X1 please return by faxing to: 570-385-5970 Terminal Code: \_\_\_\_\_

The person named herein has applied to The Evans Network of Companies to drive in a safety-sensitive position.

Name of Applicant: \*\*XX \_\_\_\_\_ Social Security Number: XX \_\_\_\_\_

I, the listed applicant, hereby authorize the following company(s) to release all records of employment, including assessments of my job performance, ability, fitness and drug testing results to The Evans Network of Companies. I hereby release the below listed company(s), and its employees, officers, directors, and agents from any and all liability of any type as a result of providing the following information to the above-mentioned company. The applicant's signature on this form releases all liability of you and your company. Information is being requested in accordance with 49 CFR Parts 40, 382 and 391.

\*\*XX \_\_\_\_\_ Applicant's Signature Date

Past Employer's Name: \_\_\_\_\_ Fax \_\_\_\_\_  
Past Employer's phone # \_\_\_\_\_ Address: \_\_\_\_\_

**To be completed by past employer:**

Dates of employment: From \_\_\_/\_\_\_/\_\_\_ To \_\_\_/\_\_\_/\_\_\_ Full Time: \_\_\_ Part-Time: \_\_\_  
Position(s) Held: \_\_\_\_\_ Local: \_\_\_\_\_ Regional: \_\_\_\_\_ Over-the-Road: \_\_\_\_\_  
Did this driver operate commercial motor vehicles greater than 26,000 lbs GVWR? \_\_\_yes \_\_\_no  
Type of equipment operated: \_\_\_Dry Van \_\_\_Flatbed \_\_\_Reefer \_\_\_Other (please list): \_\_\_\_\_  
Reason for leaving: \_\_\_Voluntary \_\_\_Lay-Off \_\_\_Terminated \_\_\_Retired  
If terminated, why? \_\_\_\_\_  
Eligible for rehire? \_\_\_Yes \_\_\_No \_\_\_Upon Review \_\_\_No, Company Policy: \_\_\_\_\_

**Motor Vehicle Accident/Equipment Damage/Incident Inquiry, If no accidents please check box  none**

Accident Date	City, State	Did the Accident Involve?	Brief Description
___/___/___	_____	Tow ___ Injury ___ Fatality ___ HM Release ___	_____
___/___/___	_____	Tow ___ Injury ___ Fatality ___ HM Release ___	_____
___/___/___	_____	Tow ___ Injury ___ Fatality ___ HM Release ___	_____
___/___/___	_____	Tow ___ Injury ___ Fatality ___ HM Release ___	_____

**Alcohol & Controlled Substance Testing Inquiry**

Has this driver ever had a breath alcohol test within the past 3 years a result of 0.04 or higher alcohol concentration?  
\_\_\_yes \_\_\_no  
Has this driver ever had a positive drug test in the past 3 years? \_\_\_\_\_ yes \_\_\_no  
Has this driver refused a controlled substance test and/or alcohol test within the past 3 years? \_\_\_\_\_ yes \_\_\_no  
Has this driver violated any other DOT drug/alcohol regulation? \_\_\_\_\_ yes \_\_\_no

To your knowledge has this driver violated any DOT drug and alcohol regulations at a previous employer? \_\_\_yes \_\_\_no

\*\*If the answer to any of the above questions is "Yes", please provide details below:

Reason for test(s): \_\_\_\_\_ Result of test(s): \_\_\_\_\_ Date of test(s): \_\_\_\_\_

If the applicant tested positive, to your knowledge, have they satisfactorily completed all return to duty and follow-up testing requirements in accordance 49 CFR 382.503? \_\_\_\_\_ yes \_\_\_no

Any other remarks: \_\_\_\_\_

Information provided by (name & job title): \_\_\_\_\_ Date: \_\_\_\_\_

First Request Date: \_\_\_/\_\_\_/\_\_\_  
Fax \_\_\_ Mail \_\_\_ Phone \_\_\_  
Attempt Made By: \_\_\_\_\_

Second Request Date: \_\_\_/\_\_\_/\_\_\_  
Fax \_\_\_ Mail \_\_\_ Phone \_\_\_  
Attempt Made By: \_\_\_\_\_

Third Request Date: \_\_\_/\_\_\_/\_\_\_  
Fax \_\_\_ Mail \_\_\_ Phone \_\_\_  
Attempt Made By: \_\_\_\_\_



OMB No. 1615-0047; Expires 06/30/08

**Form I-9, Employment Eligibility Verification**

Department of Homeland Security  
U.S. Citizenship and Immigration Services

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #
<b>I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.</b>		I attest, under penalty of perjury, that I am (check one of the following): <input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A lawful permanent resident (Alien #) A _____ <input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____	
Employee's Signature			Date (month/day/year)

**Preparer and/or Translator Certification.** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

**Section 2. Employer Review and Verification.** To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

**CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

**Section 3. Updating and Reverification.** To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____
I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.		
Signature of Employer or Authorized Representative		Date (month/day/year)



**DRIVER STATEMENT OF ON-DUTY HOURS (For Newly Hired Drivers)**

**§395.8 Driver's record of duty status.**

(j)(2) Motor carriers, when using a driver for the first time or intermittently, shall obtain from the driver a signed statement giving the total time on duty during the **immediately preceding 7 days** and the time at which the driver was last relieved from duty prior to beginning work for the motor carriers.

(k)(2) The driver shall **retain a copy** of each record of duty status for the **previous 7 consecutive days** which shall be in his/her possession and available for inspection while on duty.

(j) **Drivers used by more than one motor carrier.** (1) When the services of a driver are used by more than one motor carrier during any 24 hour period in effect at the driver's home terminal, the driver shall submit a copy of the record of duty status to each motor carrier. The record shall include:

**§395.2 Definitions.**

**On duty**, time means all time from the time a driver begins to work or is required to be in readiness to work until the time the driver is relieved from work and all responsibility for performing work. On duty time shall include:

(8) Performing any other work in the capacity, employ, or service of a motor carrier; and

(9) Performing any compensated work for a person who is not a motor carrier.

<b>NAME:</b>						<b>SSN#:</b>				
<b>LIC STATE:</b>				<b>LICENSE NO.:</b>					<b>CLASS A</b>	
<b>EXPIRES:</b>				<b>ENDORSEMENTS:</b>						
<b>DAY</b>		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>		
<b>DATE</b>									<b>TOTAL HOURS BELOW:</b>	
<b>HOURS WORKED</b>										
I hereby certify that the information given above is correct to the best of my knowledge and belief, and that I was last relieved from work/duty at the following time and date:										
<b>TIME:</b>		AM PM	<b>DATE:</b>		<b>LOCATION:</b>					
Print and sign your name:										
Are you currently leased to or are working in any capacity for another carrier/company? <input type="checkbox"/> YES <input type="checkbox"/> NO										
At this time, do you intend to work for another carrier/employer and still work for this company? <input type="checkbox"/> YES <input type="checkbox"/> NO										
I hereby certify that the information given above is true and I understand that once I contract/lease to this company, if I begin working for any additional carrier/employer(s) for compensation that I must inform this company immediately of such lease or employment activity.										
Print and sign your name:							<b>Date:</b>			
Co. witness/representative:							<b>Date:</b>			



**TRUCKER'S OCCUPATIONAL ACCIDENT INSURANCE**

**DRIVER ENROLLMENT FORM – THE EVANS NETWORK OF COMPANIES**

**OWNER OPERATORS UNDER AGE 75 POLICY OA4604469 GREAT AMERICAN INSURANCE CO**

Effective February 1, 2010

<b>Class 1 Desc of Benefits</b>	<b>Occupational</b>	<b>Non-Occupational</b>
<b>ACCIDENTAL DEATH (MAX)</b>	\$300,000 Principal Sum (\$50,000 + \$2500 per mo up to 100 mos)	\$15,000 Principal Sum (\$500 per mo up to 30 ms)
<b>ACCIDENTAL DISMEMBERMENT</b> Incl paralysis & severe burn benefits <b>INCURRAL PERIOD</b>	104 Weeks	104 Weeks
<b>ACCIDENTAL MEDICAL EXPENSE – PRIMARY</b>	\$2,000,000 Maximum Benefit Amount	\$5,000 Maximum Benefit Amount
<b>DEDUCTIBLE</b>	\$0 104 Weeks	\$0 52 Weeks
<b>RIDER LIMIT FOR: Hernia or Hemorrhoid,</b> occupational disease or occupational cumulative trauma <b>RIDER MAX BENEFIT PD</b>	\$10,000 Per Accident or Injury subject to a \$20,000 Lifetime Maximum  10 Weeks	\$10,000 Per Accident or Injury subject to a \$20,000 Lifetime Maximum  10 Weeks
<b>TEMPORARY TOTAL DISABILITY</b> Waiting Period Duration/Max Benefit Pd Rider Limit for: Hernia or Hemorrhoid or occupational disease or occ cumulative trauma <b>RIDER MAX BENEFIT PD</b>	\$700 Weekly Maximum Benefit Amount 7 Days 104 Weeks  10 Weeks	NOT COVERED
<b>CONTINUOUS TOTAL DISABILITY</b> Waiting Period Duration/Max Benefit Pd	\$700 Weekly Maximum Amount 7 Days Up to Age 70	NOT COVERED
<b>CERTIFICATE AGGREGATE &amp; COMBINED SINGLE LIMIT ANY ONE ACCIDENT</b>	<b>\$2,000,000</b>	

Item 3: The coverage provided by this policy is limited and is subject to certain conditions. Please read the policy carefully. This policy does not provide workers compensation coverage nor provide coverage for sickness. \*Social Security Retirement Age (SSRA) will vary depending upon your date of birth. If you are to reach your SSRA before satisfying the waiting period, you may not qualify for continuous total disability benefits.

Item 4: Please report claims to 1-800-297-1971

Item 5: The following forms are made a part of this policy: F.32162, F.32163, F32164, F32165, F32166, F32169, F32170, F32174, F32177, F32179, F32180, F32184, F32185, F32186, F32187, F32188, F32189, F32191, F32193, F32194, F32195, F32197, F32198, F3219, F32202, F32271A

F.32271A (West Motor Freight)





**DRIVER INFORMATION:**

**NAME:** \_\_\_\_\_ Social Security \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone # (\_\_\_\_\_) - \_\_\_\_\_

Date of Birth \_\_\_\_\_ Beneficiary's Name \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone # (\_\_\_\_\_) - \_\_\_\_\_

**Class 1 (UNDER AGE 75)- \$120.00/mo Will convert to Class 2 coverage (if applicant turns 75)**

As a participant in the Occupational Accident Insurance Program, I understand and hereby state:

1. The Occupational Accident coverage provided is not a contract for Statutory Worker's Compensation Insurance and neither my carrier nor I become participants in the Workers' Compensation system by purchasing this insurance.
2. I certify to the best of my knowledge and belief that all information on this form is complete and truthful.
3. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or any other organization, institution or person that has any records, including any medical records to furnish such information or copies of records to Great American Insurance Company, the motor carrier or the motor carrier's designee. A photographic copy of this authorization shall be as valid as the original.
4. I am an independent contractor paid by a 1099 tax form not as a W-2 employee.
5. I authorize the above named motor carrier with whom I have a contract, to take deductions in the amount indicated above from my settlement account on my behalf, and to remit premiums to Great American Insurance Company, or its appointed agent.

Driver

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



To: All Independent Contractors and Agent Partners  
 From: The Safety Department  
 Re: Distracted Driving and Cell Phone Policy

---

We deeply value the safety and well-being of all people who work within our company. Due to the increasing number of accidents nationwide resulting from the use of cell-phones and similar devices while driving, we are instituting a new policy. The policy applies any time a vehicle is operated for company business whether it is owned by the company, owned by the individual or operating on our behalf.

1. Drivers ( includes - company, owner operators, contract) and company personnel are not permitted to use a cell phone, either hand-held or hands-free, while operating a motor vehicle on company business and/or on company time. This includes but is not limited to the following:

- o Answering or making phone calls.
- o Engaging in phone conversations
- o Reading or responding to e-mails or text messages.
- o Adjusting a Global Positioning System
- o Accessing the internet, cell phone, PDA, or lap top.

2. This policy also applies to use of PDAs.

3. While driving, calls cannot be answered and must be directed to voicemail. Listen to the message when your vehicle is stopped/parked. If you are queued on a Nextel, again please be sure you are safely stopped before using the two-way to respond. *Suggestions: Place devices in vibrate or silent mode before starting your vehicle. Change your voicemail greeting to explain possible delay in returning their call because you are currently driving and are abiding by your company's distracted driving policy.*

4. If a driver must make an emergency call (911), the vehicle should be parked in a safe location before making the call. If pulling off on a highway shoulder, 4-ways and/or warning devices should be utilized right away. Also be sure all brakes are engaged.

*Drivers and company personnel will be given two warnings. The third time an employee is found to be in violation of this policy, it is grounds for immediate dismissal.*



Please sign and return the bottom portion of this policy to acknowledge you have been notified and understand the company's policy regarding use of cell phones or other communication devices.

---

Driver/Personnel Signature

Unit #/location

Date