MOTOR VEHICLE DRIVER'S CERTIFICATION OF VIOLATIONS AND ANNUAL REVIEW OF DRIVING RECORD

MOTOR CARRIER INSTRUCTIONS: Each motor carrier shall at least once every twelve months, require each driver it employs to prepare and furnish it with a list of all violations of motor vehicle traffic laws and ordinances (other than violations involving only parking) of which the driver has been convicted, or on account of which he/she has forfeited bond or collateral during the preceding twelve months (Section 391.27). Drivers who have provided information required by Section 383.31 need not repeat that information on this form.

DRIVER REQUIREMENTS: Each driver shall furnish the list as required by the motor carrier above. If the driver has not been convicted of, or forfeited bond or collateral on account of any violation which must be listed, he/she shall so certify (Section 391.27).

COMPLETED BY DR	IVER - CERTIFIC	ATION OF VIOLATIONS
Name of Driver: (Print)		
Social Security Number	Date of I	Employment
Home Terminal (City and State)		
Driver's License Number	State	Expiration Date
I certify that the following is a true and comple	ete list of traffic violations	s required to be listed (other than those I have
		ond or collateral during the past one year. (If you
have had no violations, please so state below.)		
DATE OFFENSE	LOCATION	TYPE OF VEHICLE OPERATED
	·····	
If no violations are listed above, I certify that I violation (other than those I have provided und		or forfeited bond or collateral on account of any be listed during the past twelve months.
Date Of Certification	Driver's Signature	
COMPLETED BY MOTOR C.	ARRIER - ANNUAL	L REVIEW OF DRVING RECORD
MOTOR CARRIER INSTRUCTIONS: Revie		
described in Section 391.25 of the Federal Mo	tor Carrier Safety Regula	tions. Complete the information request below.
I hereby reviewed the driving record of the above-r	named driver in accordance v	vith Section 391.25 and find that he/she (check one):
G Meets minimum requirements for safe driving	Is disqualified to dri	ve a motor vehicle pursuant to Section 391.15
Does not adequately meet satisfactory safe-drivi	ng performance	
Action taken with driver:		
····		
Reviewed by:		
Signature		Date
Leona Rieke-Young		Secretary/Safety Officer
Printed Nan	ne	Title
Max Rieke & Brothers, Inc.	15400 Midland	Dr. Shawnee, KS 66217
Motor Carrier Name	Motor Carrier Address	
	•	ON FILE. THIS DOCUMENT MAY BE PURGED
AFTER THREE YEARS FROM THE DATE	OF EXECUTION.	

EMPLOYMENT HISTORY PLEASE LIST ALL EMPLOYMENT DURING THE PAST <u>3 YEARS</u>. CMV DRIVERS SHALL ALSO PROVIDE AN <u>ADDITIONAL 7 YEARS</u>' INFORMATION ON THOSE EMPLOYERS FOR WHOM YOU OPERATED SUCH VEHICLE.

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May we contact this employer for reference? Yes No Were you subject to the FMCSRs while employed? Yes	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?					
EMPLOYMENT HISTORY (PLEASE FILL IN ALL SPACES BELOW OR MARK "N/A")					
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DOT/FMCSA Previous Employee Investigations & Inquiries

First Name	Middle Name		Last Name)	Social S	Security Number
Current Address			City	State)	Zip
Max Rieke & Brothers, Inc.			1 1		
Company Name	Driver's License Number	State	Date of Birth	Applicant	Telephone Number
I hereby authorize the above named (DOT drug and alcohol related informa eral Motor Carrier Safety Regulations, investiga-tive background inquires are along with reasons for termination of p maintain records concerning my past to obtain worker's compensation and e By signing below, I also acknowledge t	tion while previously employed as a co Part 391.23 investigation and inquiries to be made on myself including consum ast employment from previous employ activities relating to my driving, credit, o ducation records. hall have read and undersland the sum	Simmercial motor venic . In connection with, ar er, driving, and other r ers. Further, I understa civil and other experien mary of my rights unde	cle operator in the previous 3 y nd for the duration of, my employ exports. These reports will includ and that you will be requesting in a ces as well as claims involving n er The Fair Credit Reporting Acl P	ment (including contract for service le Information as to my work habits, formation from various federal, stat es in the files of insurance companie ub. L. 111-203, H.R. 4173.	pecified and required by the Fed- s) with you, I understand that performance and experience le and other agencies which
APPLICANT'S SIGNATURE				Date:	T
Previous Company Name					The information requested is
Mailing Address:		City:		StateZip	required by Part 391.23 for the
Supervisors Name)		Telepho	one Number)		U.S. Department of Transportation
				dı	Motor Carrier Safety Regula-
	DM/ TO MO, YR,	MO.	YR.		tions.
TO FORMER EMPLOYER:	Please give the following info	rmation about th	is applicant. It will be he	eld in strict confidence.	
Description Quality of Work Cooperation with Others Safety Habits Driving Skills Attendance Record	Excellent Good			Comments	
Is employment record with your Why did applicant leave? If Company policy allowed, wou Did he have custody of money of Qualified in what equipment? How many total accidents? Driver's license ever revoked of	ld you rehire? or valuables?	How many FM	CSA defined recordable ad		
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Signed:	Print Name/ Sign Name		Posilio	<u>n:</u>	Date
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Mo-Kan Construction Industry Substance Abuse Fund (CISAP) CONSENT / AUTHORIZATION FORM

Last Name		First Name	Middle Name
Street Address		City	State Zip
SS#	Phone	Cell	Date of Birth Sex
Trade Union		Employer	Max Rieke Brothers, Inc.

Consent for Photograph and Drug Testing by CISAP

I hereby give consent for the personnel of the Mo-Kan Construction Industry Substance Abuse Fund (CISAP), its designated Program Administrator, laboratory and any clinic contracted with to take my photograph and take samples of my blood and/or breath, and/or urine to test for drugs and alcohol in my body. I request this drug and/or alcohol testing voluntarily, and with no promises from anyone about what the results will be. I understand that the test(s) may disclose information that is unfavorable to me or may interfere with my current or future employment. I hereby authorize the use or disclosure of protected health information about me as described below.

Authorization to Release Photograph and Results from Program Administrator

The CISAP Program Administrator is authorized to place my photograph on my CISAP identification card and to release the results of the drug and/or alcohol test(s) regarding the sample collected today to the Mo-Kan Construction Industry Substance Abuse Fund (CISAP), its agents, attorneys, administrators, service providers, and to any union and/or employer participating in CISAP, and to any Training Trust Fund to which I am a participant. The information may be used or disclosed for determining my exposure to controlled substances. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and may no longer be protected by the federal privacy regulations.

I understand and agree that if I refuse to provide a urine specimen or if I leave a collection site before I provide a urine specimen, that such action will be treated as a positive test done by CISAP, that my Employer will be immediately notified and that I will be subject to discipline by my Employer up to and including termination.

I understand that I may revoke this authorization by notifying CISAP or its Program Administrator in writing at the address below of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by CISAP, its agents, attorneys, administrators, service providers, or any union, Training Trust Fund and/or employer participating in the program provided by CISAP in reliance on it before I revoked it.

I understand that CISAP, Program Administrator, or its agents may not condition treatment of me on whether or not I sign this authorization. I understand that refusal to sign this authorization may have an adverse effect on my current or future employment which may, in turn, affect my eligibility for employment benefits. I understand this authorization will expire 5 years from the date of execution of this document.

CISAP

Attn: CISAP Program Administrator 6405 Metcalf Avenue, #212, Overland Park KS 66202 - 913-312-5405 - Fax: 913-312-5406

			I understand the pro	ocess and I have been giv	ven a chance to ask questions.
Date			Signature		
]			T	
Photo ID			Verification		
Reason for Test	Pre-employment Re Initial Random Pos	newal st Accident	 Reasonable Sus Return to Duty Other (Expired 	e •	
		, X			
DOT Test	Yes				CISAP 03/01/2013 compliance form