

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 DRIVER - CERTIFICATION OF VIOLATIONS			
Name of Driver: (Print)			
Social Security Number		Date of Employment	
Home Terminal (City and State)			
Driver's License Number	State	Expiration Date	
I certify that the following is a true and complete list of traffic violations required to be listed (other than those I have provided under Part 383) for which I have been convicted or forfeited bond 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 have not been convicted or forfeited bond or collateral on account of any violation (other than those I have provided under Part 383) required to be listed during the past twelve months.			
Date Of Certification		Driver's Signature	

COMPLETED BY MOTOR CARRIER - ANNUAL REVIEW OF DRIVING RECORD	
MOTOR CARRIER INSTRUCTIONS: Review the Certification of Violations listed above and other information described in Section 391.25 of the Federal Motor Carrier Safety Regulations. Complete the information request below.	
I hereby reviewed the driving record of the above-named driver in accordance with Section 391.25 and find that he/she (check one):	
<input type="checkbox"/> Meets minimum requirements for safe driving <input type="checkbox"/> Is disqualified to drive a motor vehicle pursuant to Section 391.15 <input type="checkbox"/> Does not adequately meet satisfactory safe-driving performance	
Action taken with driver: _____	
Reviewed by: _____	
Signature	Date
Leona Rieke-Young	Secretary/Safety Officer
Printed Name	Title
Max Rieke & Brothers, Inc.	15400 Midland Dr. Shawnee, KS 66217
Motor Carrier Name	Motor Carrier Address

MAINTAIN THIS DOCUMENT IN THE DRIVER'S QUALIFICATION FILE. THIS DOCUMENT MAY BE PURGED AFTER THREE YEARS FROM THE DATE OF EXECUTION.

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

(NOTE: List employers in reverse order starting with the most recent.)

From:	To:	Employer:	Phone:
Immediate Supervisor:	Address:		City: State: Zip:
Starting Job Title:	Ending Job Title:	Starting Pay Rate:	Final Pay Rate:
Summarize the nature of work performed and your job responsibilities:		Reason for leaving:	
May we contact this employer for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later, not at this time. Please explain:		Were you subject to the FMCSRs while employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

EMPLOYMENT HISTORY (PLEASE FILL IN ALL SPACES BELOW OR MARK "N/A")

From:	To:	Employer:	Phone:
Immediate Supervisor:	Address:		City: State: Zip:
Starting Job Title:	Ending Job Title:	Starting Pay Rate:	Final Pay Rate:
Summarize the nature of work performed and your job responsibilities:		Reason for leaving:	
May we contact this employer for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later, not at this time. Please explain:		Were you subject to the FMCSRs while employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

EMPLOYMENT HISTORY (PLEASE FILL IN ALL SPACES BELOW OR MARK "N/A")

From:	To:	Employer:	Phone:
Immediate Supervisor:	Address:		City: State: Zip:
Starting Job Title:	Ending Job Title:	Starting Pay Rate:	Final Pay Rate:
Summarize the nature of work performed and your job responsibilities:		Reason for leaving:	
May we contact this employer for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later, not at this time. Please explain:		Were you subject to the FMCSRs while employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

EMPLOYMENT HISTORY (PLEASE FILL IN ALL SPACES BELOW OR MARK "N/A")

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Starting Job Title:	Ending Job Title:	Starting Pay Rate:	Final Pay Rate:
Summarize the nature of work performed and your job responsibilities:		Reason for leaving:	
May we contact this employer for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later, not at this time. Please explain:		Were you subject to the FMCSRs while employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			

EMPLOYMENT HISTORY (PLEASE FILL IN ALL SPACES BELOW OR MARK "N/A")

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Starting Job Title:		Ending Job Title:	Starting Pay Rate:	Final Pay Rate:	
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May we contact this employer for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later, not at this time. Please explain:			Were you subject to the FMCSRs while employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					

EMPLOYMENT HISTORY (PLEASE FILL IN ALL SPACES BELOW OR MARK "N/A")

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Immediate Supervisor:		Address:	City:	State:	Zip:
Starting Job Title:		Ending Job Title:	Starting Pay Rate:	Final Pay Rate:	
Summarize the nature of work performed and your job responsibilities:			Reason for leaving:		
May we contact this employer for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later, not at this time. Please explain:			Were you subject to the FMCSRs while employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					

EMPLOYMENT HISTORY (PLEASE FILL IN ALL SPACES BELOW OR MARK "N/A")

From:	To:	Employer:	Phone:		
Immediate Supervisor:		Address:	City:	State:	Zip:
Starting Job Title:		Ending Job Title:	Starting Pay Rate:	Final Pay Rate:	
Summarize the nature of work performed and your job responsibilities:			Reason for leaving:		
May we contact this employer for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later, not at this time. Please explain:			Were you subject to the FMCSRs while employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					

EMPLOYMENT HISTORY (PLEASE FILL IN ALL SPACES BELOW OR MARK "N/A")

From:	To:	Employer:	Phone:		
Immediate Supervisor:		Address:	City:	State:	Zip:
Starting Job Title:		Ending Job Title:	Starting Pay Rate:	Final Pay Rate:	
Summarize the nature of work performed and your job responsibilities:			Reason for leaving:		
May we contact this employer for reference? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later, not at this time. Please explain:			Were you subject to the FMCSRs while employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					

* This form needs to be completed for each employer you have worked for over the past 3 years.

DOT/FMCSA Previous Employee Investigations & Inquiries

First Name _____ Middle Name _____ Last Name _____ Social Security Number _____

Current Address _____ City _____ State _____ Zip _____

Max Rieke & Brothers, Inc.

Company Name _____ Driver's License Number _____ State _____ Date of Birth _____ Applicant Telephone Number _____

I hereby authorize the above named company to release any and all information to Max Rieke & Brothers, Inc. concerning my performance, conduct, accident record and all required DOT drug and alcohol related information while previously employed as a commercial motor vehicle operator in the previous 3 years from the date of this form as specified and required by the Federal Motor Carrier Safety Regulations, Part 391.23 investigation and inquiries. In connection with, and for the duration of, my employment (including contract for services) with you, I understand that investigative background inquiries are to be made on myself including consumer, driving, and other reports. These reports will include information as to my work habits, performance and experience along with reasons for termination of past employment from previous employers. Further, I understand that you will be requesting information from various federal, state and other agencies which maintain records concerning my past activities relating to my driving, credit, civil and other experiences as well as claims involving me in the files of insurance companies. This release may also be used to obtain worker's compensation and education records.

By signing below, I also acknowledge that I have read and understand the summary of my rights under The Fair Credit Reporting Act Pub. L. 111-203, H.R. 4173.

APPLICANT'S SIGNATURE: _____ Date: _____

Previous Company Name: _____
Mailing Address: _____ City: _____ State _____ Zip _____
Supervisors Name: _____ Telephone Number: _____
Period of Employment FROM _____ / _____ TO _____ / _____ Position Held: _____
MO. YR. MO. YR.

The information requested is required by Part 391.23 for the U.S. Department of Transportation Motor Carrier Safety Regulations.

TO FORMER EMPLOYER: Please give the following information about this applicant. It will be held in strict confidence.

Description	Excellent	Good	Fair	Poor	Supervision	Comments
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cooperation with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Safety Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Attendance Record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Is employment record with your company correct? _____

Why did applicant leave? _____

If Company policy allowed, would you rehire? _____

Did he have custody of money or valuables? _____

Qualified in what equipment? _____

How many total accidents? _____ How many FMCSA defined recordable accidents? _____

Driver's license ever revoked or suspended? _____

Yes No DOT/FMCSA Previous Employer 3-year Drug and Alcohol Investigation and Inquiry

- ☐ ☐ Did the employee have an alcohol test with results greater than 0.04 BAC?
☐ ☐ Did the employee have a verified positive test result?
☐ ☐ Did this employee refuse to be tested?
☐ ☐ Did the employee have any other violation of the DOT/FMCSR drug and alcohol testing regulations?
☐ ☐ Did the employee report any drug and alcohol rule violations to you?
☐ ☐ If you answered yes to any of the above items, did the employee complete an SAP program and return to duty test?

*** If yes, please send the employee's SAP reports, return to duty documentation and any and all follow-up test information or records.

☐ ☐ This company did not have a DOT drug/alcohol program during this period.

Signed: _____ Position: _____ Date: _____

Print Name/ Sign Name

☐

Date Sent/Initial: _____ 2nd Request Date/Initial: _____ 3rd Request Date Initial: _____

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 process and I have been given a chance to ask questions.

Date	
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Signature	
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Photo ID	
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Verification	
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Reason for Test	<input type="checkbox"/> Pre-employment	<input type="checkbox"/> Renewal	<input type="checkbox"/> Reasonable Suspicion
	<input type="checkbox"/> Initial		<input type="checkbox"/> Return to Duty
	<input type="checkbox"/> Random	<input type="checkbox"/> Post Accident	<input type="checkbox"/> Other (Expired Card)

DOT Test	Yes
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