

Full Legal Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Marital Status:    Single    Married

Commercial Driver's License # \_\_\_\_\_

Total # of Tax Dependents \_\_\_\_\_

Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_

Cell Phone # \_\_\_\_\_

\_\_\_\_\_ Home Phone # \_\_\_\_\_

Physical Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_

Began Work \_\_\_\_\_

Separation Date \_\_\_\_\_

Separation  
Circumstances \_\_\_\_\_

# Application for Employment

Company CT Commodities, Inc.

Street Address 217 W. Terra Bella Ave Drawer Q

City, State, and Zip Code Pixley, CA 93256

Name \_\_\_\_\_

First, Middle, Last

Address \_\_\_\_\_

Street

City

St

Zip

Date of Birth   /  /  

Social Security No.       -      -

Address(es) 1. \_\_\_\_\_

for the past Street City St Zip How Long?

three years 2. \_\_\_\_\_

Street City St Zip How Long?

3. \_\_\_\_\_

Street City St Zip How Long?

## EXPERIENCE & QUALIFICATIONS --- DRIVER (Attach Sheet if more space is needed)

### LICENSE

Driver Licenses	State	License No.	Type	Expiration Date

A. Have you ever been denied a license, permit, or privilege to operate a motor vehicle?

☐

Yes ☐ No

B. Has any license, permit, or privilege ever been suspended or revoked?

☐

Yes ☐ No

*If the answer to either A or B is yes, attach a statement giving details.*

### DRIVING EXPERIENCE

Class of Equipment	Type of Equipment (Van, Tank, Flat, Etc.)	From	To	Approximate Number of Miles (Total)
Straight Truck				
Tractor and Semi-Trailer				
Tractor and Two Trailers				
Other				

### ACCIDENT RECORD FOR PAST 3 YEARS OR MORE

Dates	Nature of Accident (Rear-end, Upset, Etc.)	Fatalities	Injuries

### TRAFFIC CONVICTIONS FOR PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

Location	Date	Charge	Penalty

**EMPLOYMENT RECORD (Attach sheet if more space is needed)**

*Note: Show ALL employment for the past three years and all  
Commercial Driving Experience for the past 10 years.*

Last Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Second Last Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Third Last Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Fourth Last Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

---

As a prospective employer, we must ask any applicant for a driving position with our company whether he/she has tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which the applicant applied for, but did not obtain, "safety-sensitive transportation work" (driving a commercial motor vehicle) during the past two years.

- ☐ **Yes**, I have tested positive for drugs/alcohol, or refused to take a pre-employment drug/alcohol test in the two years preceding the date of this application.
- ☐ **No**, I have not tested positive for drugs/alcohol, or refused to take a pre-employment drug/alcohol test in the two years preceding the date of this application.

DOT regulations prohibit our utilizing you to perform a "safety-sensitive function" (driving a commercial motor vehicle) if you have a positive test, or a refusal to test, until and unless you provide documents showing successful completion of the return-to-duty process in accordance with DOT regulations.

---

***To be read and signed by Applicant***

THIS CERTIFIES THAT THIS APPLICATION WAS COMPLETED BY ME, AND THAT ALL ENTRIES ON IT AND INFORMATION IN IT ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Today's Date: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

***Note: A motor carrier may require and applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.***

---

## EMPLOYMENT RECORDS (Attach sheet if more space is needed)

*Note: Show ALL employment for the past three years and all*

*Commercial Driving Experience for the past 10 years.*

Previous Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Previous Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Previous Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Previous Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Previous Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Previous Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

Previous Employer: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Position Held \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Salary \_\_\_\_\_  
Reason(s) for leaving \_\_\_\_\_  
Subject to FMCSR's? ☐ Y ☐ N Subject to drug/alcohol testing requirements per 49 CFR Part 40? ☐ Y ☐ N

THIS CERTIFIES THAT THIS APPLICATION WAS COMPLETED BY ME, AND THAT ALL ENTRIES ON IT AND INFORMATION IN IT ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Today's Date: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

**Note: A motor carrier may require and applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.**

---



**CT Commodities Inc**  
**Drawer Q**  
**Pixley, CA 93256**

**COMPANY RULES & REGULATIONS**

- No smoking is allowed while loading or unloading trucks.
- No alcoholic beverages or drugs of any kind are allowed on the job!
- No passengers are allowed in the trucks at any time.
- Follow ALL laws, including speed limits and meal breaks.
- Keep the brakes adjusted on the truck and trailers at all times.
- Check oil and water every day when you begin work or when fueling.
- You will be supplied with necessary tie down and safety equipment. If it is lost or destroyed due to your negligence, you will be required to replace it.
- Drivers are required to wash their trucks once a week and trailers once every 2 weeks.
- Keep the inside of the truck cab clean at all times.
- Perform pre-trip and post-trip inspections on truck and trailers each day, including checking the tires.
- All drivers are required to stay in communication with the home terminal, by phone, AT LEAST once every 24 hours.
- Fuel the truck after each trip.
- When rain is a possibility, keep loads tarped. Keeping the load dry is the driver's responsibility.
- To keep your heater and air conditioning working, keep passenger floorboard cleared at all times.
- Always be on time (15 minutes early wouldn't hurt).
- Make sure Freight Bill and Bill of Lading are signed at the time of each delivery. These documents will be the proof that the customer received their load.
- Turn in daily: Accurately completed Freight Bills, Bills of Lading, loading orders, weight tickets, log books, and any other documents related to loads hauled. Losing your paperwork or not having it completed properly could delay payment to CT Commodities, Inc. and to you, the driver.
- As an employee of CT Commodities, Inc., you are not allowed to be lifted atop any load, trailer, or other surface by Hay Squeezes, forklifts, or loaders of any kind.
- Employees of CT Commodities, Inc. are not permitted to use any mobile technology while driving. This includes mobile telephones, mobile computers, and similar devices. The use of these devices while driving is unsafe and in violation of the law.
- Employees of CT Commodities, Inc. have the option of pre-designation of their personal physician for work related illnesses or injuries. The required form for this option must be completed prior to any injury or illness that is work related and can be obtained from the CT Commodities, Inc. office.

By signing below, I hereby agree to follow all rules and regulations set forth by CT Commodities, Inc.

---

Driver's Printed Name

Driver's Signature

Date

NOTICE TO ALL EMPLOYEES OF CT COMMODITIES, INC.

CT Commodities, Inc. Company Credit Cards Terms and Conditions:

CT Commodities, Inc. Company Credit Cards are for fuel, oil, and truck repairs only! Any charges for personal use over \$50.00 are subject to a 25% interest charge.

\_\_\_\_\_  
Randy Terrel, Manager

I, \_\_\_\_\_, agree to these terms and conditions.

Employee

**X** \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
I, \_\_\_\_\_, give CT Commodities, Inc. and its representatives my permission to deduct from my payroll check, any charges I have made for personal use on the company credit card. I also give CT Commodities, Inc. and its representatives my permission to deduct from my payroll check any amount of money I have received as a load from the company or its representatives.

**X** \_\_\_\_\_



# Employment Eligibility Verification

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

USCIS  
Form I-9

OMB No. 1615-0047  
Expires 03/31/2016

► **START HERE.** 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-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Attestation** *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Names Used (if any)																														
Address (Street Number and Name)		Apt. Number	City or Town		State 	Zip Code																													
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												E-mail Address <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>												Telephone Number <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										

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.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States *(See instructions)*
- ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_. Some aliens may write "N/A" in this field. *(See instructions)*

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

**OR**

2. Form I-94 Admission Number: \_\_\_\_\_

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: \_\_\_\_\_

Country of Issuance: \_\_\_\_\_

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*

**3-D Barcode  
Do Not Write in This Space**

Signature of Employee:	Date (mm/dd/yyyy):
------------------------	--------------------

**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.

Signature of Preparer or Translator:		Date (mm/dd/yyyy):	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State Zip Code



**Employer Completes Next Page**



## Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:		<div>3-D Barcode Do Not Write in This Space</div>		
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

## Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions.)

Signature of Employer or Authorized Representative		Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name (Family Name)		First Name (Given Name)	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	Zip Code

## Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
--	---

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):
-----------------	------------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized 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 (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
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## LISTS OF ACCEPTABLE DOCUMENTS

### All documents must be UNEXPIRED

Employees may present one selection from List A  
or a combination of one selection from List B and one selection from List C.

<b>LIST A</b> <b>Documents that Establish Both Identity and Employment Authorization</b>	<b>OR</b>	<b>LIST B</b> <b>Documents that Establish Identity</b>	<b>AND</b> <b>LIST C</b> <b>Documents that Establish Employment Authorization</b>
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</li> </ol> </li> </ol> </li> <li>6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI</li> </ol>		<ol style="list-style-type: none"> <li>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</li> <li>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</li> <li>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</li> <li>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</li> <li>5. Native American tribal document</li> <li>6. U.S. Citizen ID Card (Form I-197)</li> <li>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>8. Employment authorization document issued by the Department of Homeland Security</li> </ol>

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).**

**Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.**

## CERTIFICATION OF COMPLIANCE WITH DRIVER LICENSE REQUIREMENTS

*This form should be read and signed by the Driver, then placed in driver qualification file.*

### NOTICE TO DRIVER

The Commercial Motor Vehicle Safety Act of 1986 provides for a new set of controls over the drivers of commercial vehicles. The new law applies to all drivers operating vehicles and combinations of vehicles with a Gross Vehicle Weight Rating (GVWR) Over 26,000 pounds, and to any vehicle regardless of weight, transporting hazardous materials.

1. No driver may have more than one license, and no motor carrier may use a driver having more than one license.
2. A driver convicted of a traffic violation (other than parking) must notify the motor carrier and the state which issued the license to that driver of such a conviction. Notification must be within 30 days of conviction.
3. Any person applying for a job as a commercial motor vehicle driver must inform the prospective employer of all previous employment as the driver of a commercial motor vehicle for the past 10 years. This is in addition to any other required information about the applicant's employment history.
4. Any violation is punishable by a fine not to exceed \$2,500. In addition, the Federal Motor Carrier Safety Regulations now require that a driver who loses any privilege to operate a commercial vehicle or who is disqualified from operating a commercial vehicle must advise the motor carrier the next business day after receiving notification of such action.

### CERTIFICATION BY DRIVER

***I hereby certify that I have read and understand the driver provisions of the Commercial Motor Vehicle Safety Act of 1986.***

Driver's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Driver's Address \_\_\_\_\_

License: State \_\_\_\_\_ Type/Class \_\_\_\_\_ ID No. \_\_\_\_\_

***I further certify that the above commercial vehicle license is the only one held or that I have surrendered the following license(s) to the states indicated.***

State \_\_\_\_\_ Type/Class \_\_\_\_\_ ID No. \_\_\_\_\_

State \_\_\_\_\_ Type/Class \_\_\_\_\_ ID No. \_\_\_\_\_

Driver's Signature: \_\_\_\_\_



A Public Service Agency

## EMPLOYER PULL NOTICE PROGRAM

### AUTHORIZATION FOR RELEASE OF DRIVER RECORD INFORMATION

I, \_\_\_\_\_, California Driver License Number, \_\_\_\_\_,  
hereby authorize the California Department of Motor Vehicles (DMV) to disclose or otherwise make available, my driving  
record, to my employer, CT Commodities, Inc.

COMPANY NAME

I understand that my employer may enroll me in the Employer Pull Notice (EPN) program to receive a driver record report at  
least once every twelve (12) months or when any subsequent conviction, failure to appear, accident, driver's license suspension,  
revocation, or any other action is taken against my driving privilege during my employment.

I am not driving in a capacity that requires mandatory enrollment in the EPN program pursuant to California Vehicle Code  
(CVC) Section 1808.1(k). I understand that enrollment in the EPN program is in an effort to promote driver safety, and that my  
driver license report will be released to my employer to determine my eligibility as a licensed driver for my employment.

EXECUTED AT: CITY <b>Pixley</b>	COUNTY <b>Tulare</b>	STATE <b>CA</b>
DATE	SIGNATURE OF EMPLOYEE <b>X</b>	

I, \_\_\_\_\_, of CT Commodities, Inc.  
AUTHORIZED REPRESENTATIVE COMPANY NAME

do hereby certify under penalty of perjury under the laws in the State of California, that I am an authorized representative of  
this company, that the information entered on this document is true and correct, to the best of my knowledge and that I am  
requesting driver record information on the above individual to verify the information as provided by said individual. This  
record is to be used by this employer in the normal course of business and as a legitimate business need to verify information  
relating to a driving position not mandated pursuant to CVC Section 1808.1. The information received will not be used for any  
unlawful purpose. I understand that if I have provided false information, I may be subject to prosecution for perjury (Penal  
Code Section 118) and false representation (CVC Section 1808.45). These are punishable by a fine not exceeding five  
thousand dollars (\$5,000) or by imprisonment in the county jail not exceeding one year, or both fine and imprisonment. I  
understand and acknowledge that any failure to maintain confidentiality is both civilly and criminally punishable pursuant to  
CVC Sections 1808.45 and 1808.46.

EXECUTED AT: CITY <b>Pixley</b>	COUNTY <b>Tulare</b>	STATE <b>CA</b>
DATE	SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE <b>X</b>	

To obtain a driver record on a prospective employee you may submit an INF 1119 form. To add this driver to the EPN Program  
you must submit the applicable forms: INF 1100, INF 1102, INF 1103, INF 1103A form. You may obtain forms at our website  
at [www.dmv.ca.gov/otherservices](http://www.dmv.ca.gov/otherservices), or by calling 916-657-6346.

THIS FORM MUST BE COMPLETED AND **RETAINED AT THE EMPLOYER'S PRINCIPAL PLACE OF BUSINESS AND**  
**MADE AVAILABLE UPON REQUEST TO DMV STAFF.**

DO **NOT** RETURN THIS FORM TO DMV.



**SIDE 1****SAFETY PERFORMANCE HISTORY RECORDS REQUEST**

**RECIPIENT EMPLOYER:** The individual identified in SECTION 1 below has indicated that you employ(ed) or use(d) him/her within the last 3 years in a position that involved the operation of a commercial motor vehicle and/or that was subject to U.S. Department of Transportation (DOT)-regulated drug and alcohol testing.

In accordance with 49 CFR §§40.25 and 391.23, we are hereby requesting that you supply us with the Safety Performance History of this individual. **Under DOT rule §391.23(g), you must respond to this inquiry within 30 days of receipt.**

Please complete SECTIONS 2 through 4 (as applicable) and return to the prospective employer shown in SECTION 1.

**APPLICANT:** Complete SECTION 1 and submit to prospective employer.

**PROSPECTIVE EMPLOYER:** Complete SECTION 5a and send form to current/previous employer. Upon receipt of completed form, complete SECTION 5b and retain.

**SECTION 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE**

I, (Print Name) _____		_____
First, M.I., Last	_____	Social Security Number
_____ hereby authorize:		_____
		Date of Birth
Previous Employer:	_____	Email: _____
Street:	_____	Telephone: _____
City, State, Zip:	_____	Fax No.: _____
to release and forward the information requested by section 4 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from _____		
(date of employment application)		
To: _____		
Prospective Employer: <b>CT COMMODITIES, INC.</b>		
Attention:	<b>Art Nez/Safety</b>	Telephone: <b>(559) 757-3995</b>
Street:	<b>217 W. Terra Bella Ave</b>	
City, State, Zip:	<b>Pixley, CA 93256</b>	
In compliance with §40.25(g) and 391.23(h), release of this information must be made in a written form that ensures confidentiality, such as fax, email, or letter.		
Prospective employer's confidential fax number: <b>(559) 427-5845 or (559) 757-1526</b>		
Prospective employer's confidential email address: <b>commodities.ct@gmail.com</b>		
_____ Applicant's Signature		_____ Date

**SECTION 2: TO BE COMPLETED BY PREVIOUS EMPLOYER****EMPLOYMENT VERIFICATION**

The applicant named above was or is employed or used by us. Yes ☐ No ☐

Employed as (job title) \_\_\_\_\_ from (m/y) \_\_\_\_\_ to (m/y) \_\_\_\_\_

Did he/she drive a motor vehicle for you? Yes ☐ No ☐ If yes, what type? Straight Truck ☐ Tractor-Semitrailer ☐ Bus ☐  
Cargo Tank ☐ Doubles/Triples ☐ Other (Specify) \_\_\_\_\_

Completed by: \_\_\_\_\_

Company: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

**Complete Sections 3 and 4 on SIDE 2 before returning.**



**SECTION 3:****TO BE COMPLETED BY PREVIOUS EMPLOYER****ACCIDENT HISTORY**

Check here ☐ if there is **no** accident register data for this driver and skip to Section 4. Complete the following for any accidents included on your accident register (§390.15(b)) that involved the applicant in the 3 years prior to the application date shown on SIDE 1.

	Date	Location	No. of Injuries	No. of Fatalities	Hazmat Spill
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Please provide information concerning any other commercial motor vehicle accidents involving the applicant that were reported to government agencies or insurers or retained under internal company policies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 4:****TO BE COMPLETED BY PREVIOUS EMPLOYER****DRUG AND ALCOHOL HISTORY**

Check here ☐ and return if applicant was **not** subject to DOT testing requirements under 49 CFR Part 40 while employed by you.

Applicant was subject to DOT testing requirements from \_\_\_\_\_ to \_\_\_\_\_.

In answering these questions, include any required DOT drug or alcohol testing information you obtained from other employers in the 3 years prior to the application date shown on SIDE 1.

Within the past 3 years from the application date shown on SIDE 1:

- |   | YES                      | NO                       |                          |
|---|--------------------------|--------------------------|--------------------------|
| 1. Has this person violated any of the drug and/or alcohol prohibitions under 49 CFR Part 40 or Subpart B of Part 382, including:   | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| • An alcohol test with a result of 0.04 or higher alcohol concentration.  |                          |                          |                          |
| • A controlled substances test result of positive, adulterated, or substituted.   |                          |                          |                          |
| • A refusal to submit to a random, post-accident, reasonable-suspicion, or follow-up controlled substances or alcohol test.   |                          |                          |                          |
| • Alcohol use while performing or within 4 hours before performing safety-sensitive functions.  |                          |                          |                          |
| • Alcohol use after an accident, in violation of §382.303.  |                          |                          |                          |
| • Controlled substances use while on duty, except as allowed under §382.213.  |                          |                          | N/A                      |
| 2. If this person violated a DOT drug and/or alcohol prohibition, did he/she fail to begin or complete a rehabilitation program prescribed by a Substance Abuse Professional (SAP)? If rehabilitation was required but you do not know if he/she began or completed such a program, check here <input type="checkbox"/> . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If this person successfully completed a SAP's rehabilitation referral and remained in your employ, did he/she subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refusal to be tested?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**SECTION 5a:****TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

This form was (check one) ☐ Faxed to previous employer ☐ Mailed ☐ Emailed ☐ Other \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

Subsequent attempts to contact previous employer (§391.23(c)(1)): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 5b:****TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

Complete below when information is obtained.

Information received from: \_\_\_\_\_

Recorded by: \_\_\_\_\_ Method: ☐ Fax ☐ Mail ☐ Email ☐ Telephone

Date: \_\_\_\_\_ ☐ Other \_\_\_\_\_



**SIDE 1****SAFETY PERFORMANCE HISTORY RECORDS REQUEST**

**RECIPIENT EMPLOYER:** The individual identified in SECTION 1 below has indicated that you employ(ed) or use(d) him/her within the last 3 years in a position that involved the operation of a commercial motor vehicle and/or that was subject to U.S. Department of Transportation (DOT)-regulated drug and alcohol testing.

In accordance with 49 CFR §§40.25 and 391.23, we are hereby requesting that you supply us with the Safety Performance History of this individual. **Under DOT rule §391.23(g), you must respond to this inquiry within 30 days of receipt.**

Please complete SECTIONS 2 through 4 (as applicable) and return to the prospective employer shown in SECTION 1.

**APPLICANT:** Complete SECTION 1 and submit to prospective employer.

**PROSPECTIVE EMPLOYER:** Complete SECTION 5a and send form to current/previous employer. Upon receipt of completed form, complete SECTION 5b and retain.

**SECTION 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE**

I, (Print Name) _____		_____
First, M.I., Last	_____	Social Security Number
_____ hereby authorize:		_____
		Date of Birth
Previous Employer:	_____	Email: _____
Street:	_____	Telephone: _____
City, State, Zip:	_____	Fax No.: _____
to release and forward the information requested by section 4 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from _____		
(date of employment application)		
To:	<b>CT COMMODITIES, INC.</b>	
Prospective Employer:	<b>Art Nez/Safety</b>	<b>(559) 757-3995</b>
Attention:	<b>217 W. Terra Bella Ave</b>	Telephone: _____
Street:	<b>Pixley, CA 93256</b>	
City, State, Zip:	_____	
In compliance with §40.25(g) and 391.23(h), release of this information must be made in a written form that ensures confidentiality, such as fax, email, or letter. <b>(559) 427-5845 or (559) 757-1526</b>		
Prospective employer's confidential fax number:	<b>commodities.ct@gmail.com</b>	
Prospective employer's confidential email address:	_____	
_____		_____
Applicant's Signature		Date

**SECTION 2: TO BE COMPLETED BY PREVIOUS EMPLOYER****EMPLOYMENT VERIFICATION**

The applicant named above was or is employed or used by us. Yes ☐ No ☐

Employed as (job title) \_\_\_\_\_ from (m/y) \_\_\_\_\_ to (m/y) \_\_\_\_\_

Did he/she drive a motor vehicle for you? Yes ☐ No ☐ If yes, what type? Straight Truck ☐ Tractor-Semitrailer ☐ Bus ☐  
Cargo Tank ☐ Doubles/Triples ☐ Other (Specify) \_\_\_\_\_

Completed by: \_\_\_\_\_

Company: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

**Complete Sections 3 and 4 on SIDE 2 before returning.**



**SECTION 3:****TO BE COMPLETED BY PREVIOUS EMPLOYER****ACCIDENT HISTORY**

Check here ☐ if there is **no** accident register data for this driver and skip to Section 4. Complete the following for any accidents included on your accident register (§390.15(b)) that involved the applicant in the 3 years prior to the application date shown on SIDE 1.

	Date	Location	No. of Injuries	No. of Fatalities	Hazmat Spill
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Please provide information concerning any other commercial motor vehicle accidents involving the applicant that were reported to government agencies or insurers or retained under internal company policies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 4:****TO BE COMPLETED BY PREVIOUS EMPLOYER****DRUG AND ALCOHOL HISTORY**

Check here ☐ and return if applicant was **not** subject to DOT testing requirements under 49 CFR Part 40 while employed by you.

Applicant was subject to DOT testing requirements from \_\_\_\_\_ to \_\_\_\_\_.

In answering these questions, include any required DOT drug or alcohol testing information you obtained from other employers in the 3 years prior to the application date shown on SIDE 1.

Within the past 3 years from the application date shown on SIDE 1:

- |   | YES                      | NO                       |                          |
|---|--------------------------|--------------------------|--------------------------|
| 1. Has this person violated any of the drug and/or alcohol prohibitions under 49 CFR Part 40 or Subpart B of Part 382, including:   | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| • An alcohol test with a result of 0.04 or higher alcohol concentration.  |                          |                          |                          |
| • A controlled substances test result of positive, adulterated, or substituted.   |                          |                          |                          |
| • A refusal to submit to a random, post-accident, reasonable-suspicion, or follow-up controlled substances or alcohol test.   |                          |                          |                          |
| • Alcohol use while performing or within 4 hours before performing safety-sensitive functions.  |                          |                          |                          |
| • Alcohol use after an accident, in violation of §382.303.  |                          |                          |                          |
| • Controlled substances use while on duty, except as allowed under §382.213.  |                          |                          | N/A                      |
| 2. If this person violated a DOT drug and/or alcohol prohibition, did he/she fail to begin or complete a rehabilitation program prescribed by a Substance Abuse Professional (SAP)? If rehabilitation was required but you do not know if he/she began or completed such a program, check here <input type="checkbox"/> . | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If this person successfully completed a SAP's rehabilitation referral and remained in your employ, did he/she subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refusal to be tested?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**SECTION 5a:****TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

This form was (check one) ☐ Faxed to previous employer ☐ Mailed ☐ Emailed ☐ Other \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

Subsequent attempts to contact previous employer (§391.23(c)(1)): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 5b:****TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

Complete below when information is obtained.

Information received from: \_\_\_\_\_

Recorded by: \_\_\_\_\_ Method: ☐ Fax ☐ Mail ☐ Email ☐ Telephone

Date: \_\_\_\_\_ ☐ Other \_\_\_\_\_



**SIDE 1****SAFETY PERFORMANCE HISTORY RECORDS REQUEST**

**RECIPIENT EMPLOYER:** The individual identified in SECTION 1 below has indicated that you employ(ed) or use(d) him/her within the last 3 years in a position that involved the operation of a commercial motor vehicle and/or that was subject to U.S. Department of Transportation (DOT)-regulated drug and alcohol testing.

In accordance with 49 CFR §§40.25 and 391.23, we are hereby requesting that you supply us with the Safety Performance History of this individual. **Under DOT rule §391.23(g), you must respond to this inquiry within 30 days of receipt.**

Please complete SECTIONS 2 through 4 (as applicable) and return to the prospective employer shown in SECTION 1.

**APPLICANT:** Complete SECTION 1 and submit to prospective employer.

**PROSPECTIVE EMPLOYER:** Complete SECTION 5a and send form to current/previous employer. Upon receipt of completed form, complete SECTION 5b and retain.

**SECTION 1:****TO BE COMPLETED BY PROSPECTIVE EMPLOYEE**

I, (Print Name)

First, M.I., Last

hereby authorize:

Social Security Number

Date of Birth

Previous Employer:

Email:

Street:

Telephone:

City, State, Zip:

Fax No.:

to release and forward the information requested by section 4 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from \_\_\_\_\_  
(date of employment application)

To:

Prospective Employer: CT COMMODITIES, INC.

Attention:

Art Nez/SafetyTelephone: (559) 757-3995

Street:

217 W. Terra Bella Ave

City, State, Zip:

Pixley, CA 93256

In compliance with §40.25(g) and 391.23(h), release of this information must be made in a written form that ensures confidentiality, such as fax, email, or letter.

Prospective employer's confidential fax number: (559) 427-5845 or (559) 757-1526Prospective employer's confidential email address: commodities.ct@gmail.com

Applicant's Signature

Date

**SECTION 2:****TO BE COMPLETED BY PREVIOUS EMPLOYER****EMPLOYMENT VERIFICATION**The applicant named above was or is employed or used by us. Yes ☐ No ☐

Employed as (job title) \_\_\_\_\_ from (m/y) \_\_\_\_\_ to (m/y) \_\_\_\_\_

Did he/she drive a motor vehicle for you? Yes ☐ No ☐ If yes, what type? Straight Truck ☐ Tractor-Semitrailer ☐ Bus ☐Cargo Tank ☐ Doubles/Triples ☐ Other (Specify) \_\_\_\_\_

Completed by:

Company:

Street:

City, State, Zip:

Telephone:

Signature:

Date:

**Complete Sections 3 and 4 on SIDE 2 before returning.**



**SIDE 2**

Employee Name: \_\_\_\_\_

Date: \_\_\_\_\_

**SECTION 3:****TO BE COMPLETED BY PREVIOUS EMPLOYER****ACCIDENT HISTORY**

Check here ☐ if there is **no** accident register data for this driver and skip to Section 4. Complete the following for any accidents included on your accident register (§390.15(b)) that involved the applicant in the 3 years prior to the application date shown on SIDE 1.

	Date	Location	No. of Injuries	No. of Fatalities	Hazmat Spill
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Please provide information concerning any other commercial motor vehicle accidents involving the applicant that were reported to government agencies or insurers or retained under internal company policies: \_\_\_\_\_

**SECTION 4:****TO BE COMPLETED BY PREVIOUS EMPLOYER****DRUG AND ALCOHOL HISTORY**

Check here ☐ and return if applicant was **not** subject to DOT testing requirements under 49 CFR Part 40 while employed by you.

Applicant was subject to DOT testing requirements from \_\_\_\_\_ to \_\_\_\_\_.

In answering these questions, include any required DOT drug or alcohol testing information you obtained from other employers in the 3 years prior to the application date shown on SIDE 1.

Within the past 3 years from the application date shown on SIDE 1:

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Has this person violated any of the drug and/or alcohol prohibitions under 49 CFR Part 40 or Subpart B of Part 382, including:   | <input type="checkbox"/> | <input type="checkbox"/> |
| • An alcohol test with a result of 0.04 or higher alcohol concentration.  |                          |                          |
| • A controlled substances test result of positive, adulterated, or substituted.   |                          |                          |
| • A refusal to submit to a random, post-accident, reasonable-suspicion, or follow-up controlled substances or alcohol test.   |                          |                          |
| • Alcohol use while performing or within 4 hours before performing safety-sensitive functions.  |                          |                          |
| • Alcohol use after an accident, in violation of §382.303.  |                          |                          |
| • Controlled substances use while on duty, except as allowed under §382.213.  |                          |                          |
| 2. If this person violated a DOT drug and/or alcohol prohibition, did he/she fail to begin or complete a rehabilitation program prescribed by a Substance Abuse Professional (SAP)? If rehabilitation was required but you do not know if he/she began or completed such a program, check here <input type="checkbox"/> . | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If this person successfully completed a SAP's rehabilitation referral and remained in your employ, did he/she subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refusal to be tested?   | <input type="checkbox"/> | <input type="checkbox"/> |

**SECTION 5a:****TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

This form was (check one) ☐ Faxed to previous employer ☐ Mailed ☐ Emailed ☐ Other \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

Subsequent attempts to contact previous employer (§391.23(c)(1)): \_\_\_\_\_

**SECTION 5b:****TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

Complete below when information is obtained.

Information received from: \_\_\_\_\_

Recorded by: \_\_\_\_\_ Method: ☐ Fax ☐ Mail ☐ Email ☐ Telephone

Date: \_\_\_\_\_ ☐ Other \_\_\_\_\_



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

INSTRUCTION: Motor carriers when using a driver for the first time shall obtain from the driver a signed statement giving the total time on-duty during the immediately preceding 7 days and time at which such driver was last relieved from duty prior to beginning work for such carrier. Rule 395.8(j)(2) Federal Motor Carrier Safety Regulations. NOTE: Hours for any compensated work during the preceding 7 days, including work for a non-motor carrier entity, must be recorded on this form.

Driver Name (Print) \_\_\_\_\_

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

Driver's License: State \_\_\_\_\_ Number \_\_\_\_\_ Class \_\_\_\_\_ Endorsement(s) \_\_\_\_\_ Restriction(s) \_\_\_\_\_

Type of License \_\_\_\_\_ Issuing State \_\_\_\_\_

DAY	1 (yesterday)	2	3	4	5	6	7	
DATE								
HOURS WORKED								TOTAL HOURS

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 at

A.M.  
P.M. On \_\_\_\_\_ Day \_\_\_\_\_ Month \_\_\_\_\_ Year

Time

\_\_\_\_\_  
Driver's Signature Date

---

## DRIVER CERTIFICATION FOR OTHER COMPENSATED WORK

---

INSTRUCTIONS: When employed by a motor carrier, a driver must report to the carrier all on-duty time including time working for other employers. The definition of on-duty time found in Section 395.2 paragraphs (8) and (9) of the Federal Motor Carrier Safety Regulations includes time performing any other work in the capacity of, or in the employ or service of, a common, contract or private motor carrier, also performing any compensated work for any nonmotor carrier entity.

(check one)

Are you currently working for another employer? ☐ Yes ☐ No

At this time do you intend to work for another employer while still employed by this company? ☐ Yes ☐ No

I hereby certify that the information given above is true and I understand that once I become employed with this company, if I begin working for any additional employer(s) for compensation that I must inform this company immediately of such employment activity.

\_\_\_\_\_  
Driver's Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
Company Representative

\_\_\_\_\_  
Date

## NOTICE TO EMPLOYEE

*Labor Code section 2810.5*

### EMPLOYEE

Employee Name: \_\_\_\_\_

Start Date: \_\_\_\_\_

### EMPLOYER

Legal Name of Hiring Employer: CT Commodities, Inc.

Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? ☐ Yes ☐ No

Other Names Hiring Employer is "doing business as" (if applicable):  
\_\_\_\_\_

Physical Address of Hiring Employer's Main Office:

217 W. Terra Bella Ave Pixley, CA 93256

Hiring Employer's Mailing Address (if different than above):

PO Box Q Pixley, CA 93256

Hiring Employer's Telephone Number: \_\_\_\_\_

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: \_\_\_\_\_

Physical Address of Main Office: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

### WAGE INFORMATION

Rate(s) of Pay: \_\_\_\_\_ Overtime Rate(s) of Pay: \_\_\_\_\_

Rate by (check box): ☐ Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece rate ☐ Commission

☐ Other (provide specifics): \_\_\_\_\_

Does a written agreement exist providing the rate(s) of pay? (check box) ☐ Yes ☐ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? ☐ Yes ☐ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):  
\_\_\_\_\_

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: Weekly on Fridays

## WORKERS' COMPENSATION

Insurance Carrier's Name: Berkshire Hathaway Homestate Companies

Address: PO Box 881236 San Francisco, CA 94188

Telephone Number: (888) 495-8949

Policy No.: CTWC138579

☐ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: \_\_\_\_\_

## PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

- a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
- b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
- c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
  1. requesting or using accrued sick days;
  2. attempting to exercise the right to use accrued paid sick days;
  3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
  4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: *(Check one box)*

- ☐ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
- ☐ 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
- ☒ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.
- ☐ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption): \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT

*(Optional)*

\_\_\_\_\_  
(PRINT NAME of Employer representative)

\_\_\_\_\_  
(PRINT NAME of Employee)

\_\_\_\_\_  
(SIGNATURE of Employer Representative)

\_\_\_\_\_  
(SIGNATURE of Employee)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)

The employee's signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.



**AVISO AL EMPLEADO**  
*Sección 2810.5 del Código de Trabajo*

**EMPLEADO**

Nombre del empleado: \_\_\_\_\_

Fecha de inicio: \_\_\_\_\_

**EMPLEADOR**

Nombre legal del empleador contratante: CT Commodities, Inc.

¿El empleador contratante es una agencia/compañía de empleo (por ejemplo, agencia de colocación de trabajadores temporales, agencia de empleados temporales, u organización de empleadores profesionales [PEO, por sus siglas en inglés])? ☐ Sí ☐ No

Otros nombres con los cuales el empleador contratante "realiza negocios" (si aplica):  
\_\_\_\_\_

Dirección física de la oficina principal del empleador contratante:

217 W. Terra Bella Ave Pixley, CA 93256

Dirección postal del empleador contratante (si es diferente a la de arriba):

PO Box Q Pixley, CA 93256

Número telefónico del empleador contratante: 559-757-3995

Si el empleador contratante es una agencia/compañía de colocación de trabajadores (la casilla de arriba está marcada "Sí"), a continuación se encuentra la otra entidad para la cual el empleado trabajará:

Nombre: \_\_\_\_\_

Dirección física de la oficina principal: \_\_\_\_\_

Dirección postal: \_\_\_\_\_

Número telefónico: \_\_\_\_\_

**INFORMACIÓN SOBRE EL SALARIO**

Tasa(s) de pago: \_\_\_\_\_ Tasa(s) de pago de horas extra: \_\_\_\_\_

Tasa por (marque una casilla): ☐ Hora ☐ Turno ☐ Día ☐ Semana ☐ Salario ☐ A destajo ☐ Comisión

☐ Otra (proporcione detalles): \_\_\_\_\_

¿Existe un acuerdo por escrito que proporcione la(s) tasa(s) de pago? (marque una casilla) ☐ Sí ☐ No

Si la respuesta es Sí, ¿todas las tasas de pago y sus bases están contenidas en ese acuerdo por escrito? ☐ Sí ☐ No

Asignaciones, si las hubiere, reclamadas como parte del salario mínimo (incluyendo asignaciones por concepto de comidas o alojamiento):  
\_\_\_\_\_

(Si el empleado ha firmado el acuse de recibo a continuación, el mismo no constituye un "acuerdo escrito voluntario" requerido por la ley entre el empleador y el empleado para poder considerarlo como un crédito por concepto de comidas o alojamiento contra el salario mínimo". Cualquiera de tales acuerdos escritos voluntarios deberán documentarse por separado.)

Día regular de pago: cada Viernes

## INDEMNIZACIÓN POR ACCIDENTES DE TRABAJO

Nombre de la aseguradora: Berkshire Hathaway Homestate Companies

Dirección PO Box 881236 San Francisco, CA 94188

Número telefónico: (888) 495-8949

No. de la póliza: CTWC138579

☐ Auto asegurado (Código de Trabajo 3700) y número de certificado del consentimiento para auto asegurarse: \_\_\_\_\_

## LICENCIA POR ENFERMEDAD CON GOCE DE SUELDO

Salvo que esté exento, el empleado identificado en este aviso tiene derecho a los requisitos mínimos para licencias por enfermedad con goce de sueldo bajo la ley del estado que estipula que un empleado:

- Puede acumular licencia por enfermedad con goce de sueldo y puede solicitar y utilizar hasta 3 días o 24 horas por concepto de licencia por enfermedad con goce de sueldo por año;
- No podrá ser despedido o no se podrán tomar represalias contra él por utilizar o por solicitar el uso de licencias por enfermedad con goce de sueldo; y
- Tiene derecho de presentar una demanda contra el empleador que tome represalias o discrimine contra un empleado por
  - solicitar o utilizar días por concepto de licencias por enfermedad con goce de sueldo;
  - intentar ejercer el derecho de utilizar días acumulados por concepto de licencias por enfermedad con goce de sueldo;
  - presentar una demanda o alegar una violación de la sección 245 y siguientes del Artículo 1.5 del Código de Trabajo de California;
  - cooperar en una investigación o enjuiciamiento debido a una presunta violación de este Artículo u oponerse a cualquier política o práctica o actuación que sea prohibida por la sección 245 y siguientes del Artículo 1.5 del Código de Trabajo de California.

Lo siguiente aplica al empleado identificado en este aviso. *(Marque una casilla)*

- ☐ 1. Acumula licencia por enfermedad con goce de sueldo únicamente según los requisitos mínimos previstos en el Código de Trabajo §245 y siguientes con ninguna otra póliza del empleador que proporcione términos adicionales o diferentes para acumular y utilizar la licencia por enfermedad con goce de sueldo.
- ☐ 2. Acumula licencia por enfermedad con goce de sueldo según la póliza del empleador que satisface o excede los requisitos de acumulación, traslado, y uso del Código de Trabajo §246.
- ☒ 3. El empleador provee no menos de 24 horas (o 3 días) de licencia por enfermedad con goce de sueldo al principio de cada período de 12 meses.
- ☐ 4. El empleado está exento de la protección de ser pagado por concepto de licencias por enfermedad con goce de sueldo según el Código de Trabajo §245.5. (Proporcione la exención y la sub-sección específica para la exención): \_\_\_\_\_

## ACUSE DE RECIBO

*(Opcional)*

\_\_\_\_\_  
(ESCRIBA CON LETRA DE MOLDE EL NOMBRE del representante del empleador)

\_\_\_\_\_  
(ESCRIBA CON LETRA DE MOLDE el nombre del empleado)

\_\_\_\_\_  
(FIRMA del representante del empleador)

\_\_\_\_\_  
(FIRMA DEL empleado)

\_\_\_\_\_  
(Fecha)

\_\_\_\_\_  
(Fecha)

La firma del empleado en este aviso únicamente constituye un acuse de recibo.

La sección 2810.5(b) del Código de Trabajo requiere que el empleador le notifique a usted por escrito de cualquier cambio a la información establecida en este Aviso dentro de los siete días continuos después del momento de los cambios, a menos que uno de los siguientes aplique:

(a) Todos los cambios son reflejados en un recibo puntual de sueldo provisto según la sección 226 del Código de Trabajo; (b) El aviso de todos los cambios se provee en otro escrito requerido por la ley dentro de siete días a partir de los cambios.



Drawer Q Pixley, CA 93256

Phone: (559)757-3995 or (559)757-3996

Fax: (559)757-1526

Email: [commodities.ct@gmail.com](mailto:commodities.ct@gmail.com)

## **General Consent for Limited Queries of the Federal Motor Carrier Safety Administration (FMCSA) Drug and Alcohol Clearinghouse**

I, \_\_\_\_\_, hereby provide consent to CT Commodities, Inc. to conduct a limited query of the FMCSA Commercial Driver's License Drug and Alcohol Clearinghouse to determine whether drug or alcohol violation information about me exists in the Clearinghouse. I, \_\_\_\_\_, give CT Commodities, Inc. consent to unlimited queries for pre-employment and throughout the duration of my employment with CT Commodities, Inc.

I understand that if the limited query conducted by CT Commodities, Inc. indicates that drug or alcohol violation information about me exists in the Clearinghouse, FMCSA will not disclose that information to CT Commodities, Inc. without first obtaining additional specific consent from me.

I further understand that if I refuse to provide consent for CT Commodities, Inc. to conduct unlimited queries of the Clearinghouse, CT Commodities, Inc. must prohibit me from performing safety-sensitive functions, including driving a commercial motor vehicle, as required by FMCSA's drug and alcohol program regulations.

---

Employee Signature

Date

# **CT** *Commodities, Inc.*

Drawer Q Pixley, CA 93256

**Phone:** (559)757-3995 or (559)757-3996  
**Fax:** (559)757-1526  
**Email:** [commodities.ct@gmail.com](mailto:commodities.ct@gmail.com)

Dear New Hire \_\_\_\_\_

We are pleased that you have chosen to accept our offer of employment for Truck Driver and look forward to your first day of work on \_\_\_\_\_ of 20\_\_\_\_. We believe you'll find working at CT Commodities, Inc. to be a rewarding experience.

CT Commodities, Inc. uses a 90 day probationary period for new employees. This time frame lets CT Commodities, Inc assess your readiness for the position as well as allows us to determine your ability to do the job.

CT Commodities, Inc. has the right to terminate for any of the following reasons:

Tickets, accidents, no call/no show, not being on time, absence, attitudes towards customers/co-workers, not following state and federal laws with hours of service.

At the end of the probationary period, if we confirmed that you are able to meet all job requirements, you will be eligible to receive all normal and customary benefits of a regular full time employee.

We wish you great success in your new position!

X \_\_\_\_\_

## DRIVER CERTIFICATE OF RECEIPT

This document certifies that I have received, read, and understand at least the following materials regarding the DOT/FMCSA 49 CFR §382 Regulations on Controlled Substances and Alcohol Use and Testing:

- **The Company Policy** on Alcohol Misuse and Controlled Substance Use,
- **This entire Driver Reference Guide** regarding the DOT/FMCSA 49 CFR §382 regulations on Controlled Substances and Alcohol Use and Testing which included at least the following:
  1. The identity of the person designated to answer driver questions about these materials,
  2. The categories of drivers who are subject to the provisions of this regulation,
  3. Information on what period of the workday I am required to be in compliance with this regulation,
  4. Specific information concerning my conduct that is prohibited by this regulation,
  5. The circumstances under which I will be tested for alcohol and/or controlled substances under this regulation,
  6. The procedures that will be used to test for the presence of alcohol and controlled substances, protect the driver and the integrity of the testing processes, safeguard the validity of the test results, and ensure that those results are attributed to the correct driver,
  7. The requirement that a driver submit to alcohol and controlled substances tests administered in accordance with this regulation,
  8. An explanation of what constitutes a refusal to submit to an alcohol or controlled substances test and the attendant consequences,
  9. The consequences for drivers found to have violated the prohibitions of this regulation, including the requirement that the driver be removed immediately from safety-sensitive functions,
  10. The consequences for drivers found to have an alcohol concentration of 0.02 or greater but less than 0.04,
  11. Information concerning the effects of alcohol and controlled substances use on an individual's health, work, and personal life; signs and symptoms of an alcohol or a controlled substances problem (the driver's or a coworker's); and available methods of intervening when an alcohol or a controlled substances problem is suspected, including confrontation, referral to any employee assistance program and or referral to management.
- **Certificate of receipt.** Each employer shall ensure that each driver is required to sign a statement certifying that he or she has received a copy of these materials described in this section. Each employer shall maintain the original of the signed certificate and may provide a copy of the certificate to the driver.

SIGN and DATE:

Driver \_\_\_\_\_ Date \_\_\_\_\_

Company Official \_\_\_\_\_ Date \_\_\_\_\_

Company Name CT Commodities, Inc.

***Copy this page, have Co. official and driver sign both copies. Retain for 5 years.***