TAYO TRANSIT LLC

Phone: _____

INQUIRY TO PAST EMPLOYERS

APPLICANT'S NAME_____ SSN _____

I hereby authorize the release of all records of employment including assessments of job performance, ability and fitness, character, work habits, performance, traffic offenses, experience, and reason for termination. Additionally, I the release of all records regarding ***alcohol test results*** with a concentration result of 0.04 or greater and ***controlled substances test results,*** any alcohol or controlled substances test refusals and information on any required substance abuse professional evaluation, determination of need for assistance and information to _____ and release all such persons or companies supplying information from any liability.

APPLICANT'S SIGNATURE _____ DATE ____/____/_____

SPACE BELOW THIS LINE FOR OFFICIAL OFFICE USE ONLY
APPLICANT IS NOT TO CONTINUE.

Company Name _____Phone _____ Fax _____

The person named above has applied for employment as a Commercial Driver. Your firm is listed by the applicant as a past employer. Please respond to the inquiry ***within 24 hours, or by the end of the next working day,*** *being as factual and accurate as possible.*

1. Employment Period: from _____ to _____ Position Held: _____

2. Motor Vehicle Experience: ( ) Company Driver ( ) Owner-Operator ( ) Conventional Tractor ( ) Cab-Over Tractor ( ) Straight Truck ( ) Dry Van Trailer ( ) Reefer Trailer ( ) Flat Bed Trailer ( ) Specialized Trailer ( ) Tow Vehicle

3. Commodities Transported: ( ) Building Materials ( ) Refrigerated ( ) Dry Products ( ) Automobiles
( ) Machinery ( ) Towed Vehicles ( ) Other _____

4. Areas of Operation: ( ) Continental U.S. ( ) Canada ( ) Regional ( ) City & Local Driving

5. Accident History: (Prior 3 Years) Date Type Location P/NP Fatalities
A1 _____
A2 _____
A3 _____

6. Substance Abuse Information: Has this applicant in the past 3 years:	YES	NO
A. Had an alcohol test with a result of 0.04 or higher	( )	( )
B. Had a verified positive drug test	( )	( )
C. Refused to be tested for any controlled substance or alcohol	( )	( )
D. Has applicant committed other violations of DOT drug or alcohol test regulations	( )	( )

IF YES TO ANY OF THE ABOVE QUESTIONS, please release any documentation relating to the S.A.P's evaluation, determination, and compliance, give the Substance Abuse Professional's name, address and phone number, successful completion of DOT return-to-duty tests, including follow-up testing.

Name_____ Phone No. _____

Address _____ City _____ St _____ Zip _____

NOTE: Failure to furnish information as requested by 49 CFR 382.405 and 382.413 is a violation of the U.S. Dept. of Transportation, Federal Motor Carrier Safety Administration. Failure to provide this information may result in a fine and/or civil liability.

Completed by: _____ Position _____Date _____

ACKNOWLEDGEMENT OF NOTICE OF
TAYO TRANSIT LLC
DRUG ABUSE POLICY AND PROCEDURES
AND
CONSENT TO PRE-EMPLOYMENT DRUG TESTING

I, _____, acknowledge receiving written notice of the existence of the _____ Drug Abuse Policy (the "Policy").

As a condition of contractual service to the Company, I understand and agree that I must not use, buy sell, accept as a gift, experiment with, traffic in or otherwise be involved with illicit or inappropriate drugs when it could affect the safe performance of my job.

I understand that the Policy does not apply to medication properly taken as prescribed by a licensed physician, except as provided by the Policy.

I further understand and agree that, if I become an Contactor with the Company, I may be required to submit to urinalysis for the detection of prohibited substance, and a saliva or breath alcohol test for alcohol use (herein referred to as "testing") for the detention of prohibited substances based upon suspicion, following a reportable accident or an on-the-job accident, when returning from a leave of absence, and on a random basis.

I further understand and agree if I become an contactor for the Company, and in the event that any test result is Positive, I will have an opportunity to discuss with the Company's Medical Review Officer my medical history and/or any other relevant biomedical factors to enable the MRO to determine whether there is an alternate medical explanation for a positive result. In order to aid the MRO in his/her investigation, I hereby authorize any hospital, physician, dentist or pharmacist to release to the MRO all medial records and to freely discuss with the MRO all maters concerning drugs prescribed to me or treatments performed on me which may be connected to a positive test result.

I further understand that refusal to submit to testing when requested to do so by a supervisor or manager, will result in discipline up to and including termination.

My signature below indicates my understanding of this Policy and what is expected of me, my consent to be tested and my authorization to release to any collection site personnel, Medical Review Officer or Company representative, the information necessary to comply with this Policy.

APPLICANT'S SIGNATURE _____ DATE ____/____/_____

WITNESS' SIGNATURE _____ DATE ____/____/_____

Driver Applicant Pre-Employment
Alcohol and Controlled Substances Statement

Section 40.25(j) of the Federal Motor Carrier Safety Regulations requires each motor carrier to inquire of prospective drivers and prospective drivers are required to respond to the information in the question below.

Applicant Name _____

Social Security # _____

During the past three (3) years, have you, the applicant, tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which you applied for, but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol testing rules?

YES _____ NO _____

If the answer to the above question is YES, please list the motor carrier(s) below:

Name of Motor Carrier _____

Address_____City_____State_____ZIP_____

Telephone Number (_____) _____ - _____

In addition, if the answer to the above question was "Yes", please list the name and contact information for the Substance Abuse Professional (SAP) who completed your evaluation. If you answered "Yes" to the question above, please provide documentation of your successful completion of the return-to-duty process required by Part 40 Subpart O.

Name of SAP _____

Address_____City_____State_____ZIP_____

Phone (____) ____ - _____

APPLICANT'S SIGNATURE _____ DATE ____/____/_____

WITNESS' SIGNATURE _____ DATE ____/____/_____