

## PRE-EMPLOYMENT DOT PACKET CHECKLIST

All documents listed below must be completed and returned to the office **before employment begins**.

### Required Documents (Complete All That Apply)

#### Driver's License

**\*Provide a copy of the employee's driver's license (front and back).**

Driver's License Number: \_\_\_\_\_

State: \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

#### Social Security Card

**\*Provide a copy of the employee's Social Security card.**

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

#### \*Copy Of Medical Card

#### Pre-Employment Drug Test

All employees must complete a pre-employment drug test prior to starting work. Testing type is based on the employee's position:

- DOT FMCSA Drug Test (CDL Employees)
- DOT PHMSA Drug Test (Line Locating Employees)
- Non-DOT Drug Test (All Other Employees)

Employees must sign the Chain of Custody form at the time of testing. A copy of the Chain of Custody form must be returned with this packet.

#### Employee Acknowledgement

By signing below, I confirm I have provided the required documents listed above and understand I may not begin work until all required items are completed and submitted.

Employee Name (Print): \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

## FMCSA DRUG & ALCOHOL CLEARINGHOUSE – LIMITED QUERY CONSENT (2026)

This consent form applies to employees/applicants in positions subject to **DOT/FMCSA drug and alcohol testing regulations**. The Federal Motor Carrier Safety Administration (FMCSA) requires employers to conduct queries of the **FMCSA Drug & Alcohol Clearinghouse** for certain CDL/DOT-regulated positions.

### PURPOSE

The Company must conduct a **Limited Query** of the FMCSA Drug & Alcohol Clearinghouse to determine whether any information exists about the employee/applicant that would prohibit them from performing safety-sensitive functions.

### EMPLOYEE / APPLICANT CONSENT

By signing below, I provide my consent for the Company to conduct a **Limited Query** of the FMCSA Drug & Alcohol Clearinghouse: **prior to performing safety-sensitive functions, and at least annually while employed in a DOT-regulated position, as required.**

I understand that:

- If the Limited Query indicates that information exists in the Clearinghouse, I will be required to provide **electronic consent** in the FMCSA Clearinghouse for the Company to conduct a **Full Query**.
- Refusal to provide consent may result in the Company being unable to hire me, continue my employment, or allow me to perform safety-sensitive functions.

### RELEASE OF INFORMATION

I understand that Clearinghouse query results may be used for employment-related and compliance purposes, including determining my eligibility to operate a Commercial Motor Vehicle (CMV) and perform DOT-regulated duties.

### Employee Acknowledgement

Employee Name (Print): \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

CDL State Issued: \_\_\_\_\_

CDL Number: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

# DOT EMPLOYMENT APPLICATION (CDL / DRIVER POSITION)

*The Company is an Equal Opportunity Employer. Applicants are considered without regard to race, color, religion, sex, national origin, age, disability, or any other protected status.*

## APPLICANT INFORMATION

Full Legal Name (First, Middle, Last): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## POSITION INFORMATION

Position Applying For: \_\_\_\_\_

Date Available to Start: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Full-Time  Part-Time  Temporary

Have you ever worked for this Company before?  Yes  No

If yes, when? \_\_\_\_\_

## DRIVER LICENSE INFORMATION

List Licenses held within the previous 3 years

Driver's License Number: \_\_\_\_\_ Class \_\_\_\_\_ State Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Driver's License Number: \_\_\_\_\_ Class \_\_\_\_\_ State Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Driver's License Number: \_\_\_\_\_ Class \_\_\_\_\_ State Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## DRIVING EXPERIENCE

Type of Equipment Operated (check all that apply):

Pickup / Trailer  Flatbed  Lowboy  Tanker  Stepdeck  Dump Truck  Winch Truck  Crane Truck

Other: \_\_\_\_\_

Total Years Driving Experience: \_\_\_\_\_

Approximate Miles Driven (past 12 months): \_\_\_\_\_

## ACCIDENTS & VIOLATIONS

### Accidents (past 3 years)

List all accidents involving any vehicle (commercial or personal).

1. Date: \_\_\_\_\_ Location: \_\_\_\_\_ Description: \_\_\_\_\_
2. Date: \_\_\_\_\_ Location: \_\_\_\_\_ Description: \_\_\_\_\_
3. Date: \_\_\_\_\_ Location: \_\_\_\_\_ Description: \_\_\_\_\_

None

### Traffic Violations (past 3 years)

List all moving violations (excluding parking violations).

1. Date: \_\_\_\_\_ Violation: \_\_\_\_\_ State: \_\_\_\_\_
2. Date: \_\_\_\_\_ Violation: \_\_\_\_\_ State: \_\_\_\_\_
3. Date: \_\_\_\_\_ Violation: \_\_\_\_\_ State: \_\_\_\_\_

None

## EMPLOYMENT HISTORY (PAST 3 YEARS REQUIRED / 10 YEARS PREFERRED)

### Current or Most Recent Employer

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

Supervisor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address/City/State: \_\_\_\_\_

Job Title: \_\_\_\_\_ Dates Employed: / to /

Reason for Leaving: \_\_\_\_\_

### Previous Employer

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

Supervisor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address/City/State: \_\_\_\_\_

Job Title: \_\_\_\_\_ Dates Employed: / to /

Reason for Leaving: \_\_\_\_\_

**Previous Employer**

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

Supervisor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address/City/State: \_\_\_\_\_

Job Title: \_\_\_\_\_ Dates Employed: / to /

Reason for Leaving: \_\_\_\_\_

**CDL / DOT QUESTIONS**

Have you ever had a CDL suspended, revoked, or denied?  Yes  No

If yes, explain: \_\_\_\_\_

Have you ever failed or refused a DOT drug or alcohol test?  Yes  No

If yes, explain: \_\_\_\_\_

Are you currently prohibited from performing safety-sensitive functions?  Yes  No

If yes, explain: \_\_\_\_\_

**EMERGENCY CONTACT**

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

Phone Number: \_\_\_\_\_

**APPLICANT CERTIFICATION & AUTHORIZATION**

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that false or misleading information may result in refusal to hire or termination if discovered after employment begins.

I authorize the Company to verify employment, driving history, and other information as needed for employment purposes, including requesting my **Motor Vehicle Record (MVR)** and conducting applicable **DOT/FMCSA compliance queries**.

Applicant Name (Print): \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

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

# REQUEST FOR MOTOR VEHICLE RECORD (MVR)

The Company may require a Motor Vehicle Record (MVR) for employment purposes.

By completing and signing this form, the employee authorizes the Company to request and obtain their driving record.

## Employee Information

Full Name (First, Middle, Last): \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Driver's License Number: \_\_\_\_\_

State Issued: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## Employee Authorization

I authorize the Company to obtain my Motor Vehicle Record (MVR) for employment purposes. I understand this information may be used to determine eligibility for driving Company vehicles or performing job duties requiring driving.

Employee Signature: \_\_\_\_\_

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

## Medication Disclosure (Safety-Sensitive Position)

Are you currently taking any prescription or over-the-counter medications that may impair or affect your ability to safely operate a commercial motor vehicle?  Yes  No

If yes, please list medication name(s) below:

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# DRUG TEST AUTHORIZATION (PRE-EMPLOYMENT)

All employees are required to complete a pre-employment drug test before beginning work.

## Testing Locations

Drug testing must be completed through Intermountain Toxicology Collections at one of the following locations:

Roosevelt Location:  
Intermountain Toxicology Collections  
248 N Union St  
Roosevelt, UT 84066

Colorado Location:  
ErgoMed Work Systems  
4663 W 20th Street Rd  
Greeley, CO 80634

Vernal Location:  
Intermountain Toxicology Collections  
38 E 100 N  
Vernal, UT 84078

## Services to be Performed (circle all that apply):

ITC DOT FMCSA Drug                      ITC DOT FMCSA Alcohol    ITC DOT PHMSA Drug  
ITC Non-DOT Drug                      ITC Non-DOT Alcohol

## Employee Authorization

By signing below, I authorize the company to request and obtain drug testing results for employment purposes.

Employee Name (Print): \_\_\_\_\_

Employee Signature: \_\_\_\_\_

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

## Medication Disclosure (Safety-Sensitive Position)

Are you currently taking any prescription or over-the-counter medications that may impair or affect your ability to safely operate a commercial motor vehicle?  Yes  No

If yes, please list medication name(s) below:

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E&B DOT: IMQ.VERN.EBOILFLD

E&B NON DOT: IM.,NVER.EBOILFLD

HAWK DOT: IMQ.VERN.4292285

HAWK NON DOT: IMQ.NVER.4292285

## PREVIOUS PRE-EMPLOYMENT DRUG & ALCOHOL TEST STATEMENT (DOT)

The prospective employee is required to answer the following questions:

**Prospective Employee Name (Print):** \_\_\_\_\_

**Employee Code (if applicable):** \_\_\_\_\_

### 1) Previous Pre-Employment Test Result

Have you tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer that you applied for, but did not obtain safety-sensitive transportation work covered by DOT drug and alcohol testing rules during the past **two (2) years**?

Yes  No

### 2) Return-to-Duty Requirements

If you answered **YES**, can you provide proof that you have successfully completed the DOT return-to-duty requirements?

Yes  No  N/A

I certify that the information provided on this document is true and correct.

**Prospective Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Witness Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# DRUG & ALCOHOL PREVIOUS EMPLOYER INQUIRY (DOT/FMCSA)

## PART 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

Employee / Applicant Name (First, Middle, Last): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Authorization

I hereby authorize the release of information regarding my DOT drug and alcohol testing history while employed by:

Previous Employer: \_\_\_\_\_

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

City, State, ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

To the prospective employer listed below. I release the previous employer and all parties providing the information from any and all liability that may result from furnishing this information.

Prospective Employer: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## PART 2: TO BE COMPLETED BY PREVIOUS EMPLOYER

If the employee/applicant was **NOT** subject to DOT drug and alcohol testing requirements while employed by your company, please check below:

**Not Subject**

Reason employee was not subject: \_\_\_\_\_

The employee/applicant named above was employed by us from (MM/YYYY) \_\_\_\_\_ to (MM/YYYY) \_\_\_\_\_

Please answer the following for the **previous 3 years**, as required by **49 CFR 382.413**:

1. **Did this person have an alcohol test with a result of 0.04 or higher?**  
 Yes  No  
If yes, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_
  
2. **Did this person test positive, adulterate, or substitute a test specimen for controlled substances?**  
 Yes  No  
If yes, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_
  
3. **Did this person refuse to submit to a post-accident, random, reasonable suspicion, follow-up, or return-to-duty controlled substance test?**  
 Yes  No  
If yes, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_
  
4. **Did this person commit any other violation of DOT drug and alcohol regulations (49 CFR Part 382 or Part 40)?**  
 Yes  No  
If yes, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_
  
5. **If this person violated a DOT drug and alcohol regulation, did they complete a SAP-prescribed rehabilitation program in your employ, including return-to-duty and follow-up tests?**  
 Yes  No  
If yes, please provide documentation with this form.
  
6. **After completing SAP requirements, did the driver have a verified positive drug test, alcohol test result of 0.04 or greater, or a refusal to test?**  
 Yes  No  
If yes, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**Employer Certification**

**Print Name:** \_\_\_\_\_

**Position/Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**NOTICE** In answering these questions, include any required DOT drug and alcohol testing information obtained from prior employers in the previous **3 years** prior to the application date.

Federal Motor Carrier Safety Regulations require that we receive your reply within **14 days** of this request.

# DRIVER STATEMENT OF ON-DUTY HOURS (FOR NEWLY HIRED DRIVERS)

## Instructions

Motor carriers using a driver must obtain a signed statement from the driver that shows the total time on-duty during the **immediately preceding 7 days**, and the time the driver was last relieved from duty prior to beginning work for the motor carrier. This is required under **49 CFR 395.8(j)(2)**.

**NOTE:** Hours worked for any compensated work during the preceding 7 days, including work for a non-motor carrier entity, must be recorded on this form.

## Driver Information

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

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Driver's License Number: \_\_\_\_\_

Type of License:  CDL  Non-CDL State: \_\_\_\_\_

Endorsements (if applicable): \_\_\_\_\_

Restrictions (if applicable): \_\_\_\_\_

## On-Duty Hours (Previous 7 Days)

Fill in hours worked for each day listed below:

Day	1	2	3	4	5	6	7
	(Yesterday)						
Date	_____	_____	_____	_____	_____	_____	_____
Hours Worked	_____	_____	_____	_____	_____	_____	_____

## Last Time Relieved From Work

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:

Time: \_\_\_\_\_  AM  PM On (Date): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Driver 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 is found in **49 CFR 395.2** and includes time performing any other work as an employee, in the employ or service of a common, contract, or private motor carrier, as well as performing any compensated work for any non-motor carrier entity.

## Other Employment Disclosure

**1. Are you currently working for another employer?**

Yes  No

**2. At this time, do you intend to work for another employer while still employed by this Company?**

Yes  No

## Certification

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

**Driver Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**Witness (Company Representative):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_