

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:

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:

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 (Yesterday)	2	3	4	5	6	7
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:** _____ / _____ / _____