

DISCLOSURE AND RELEASE FORM

SERVICES TO BE PERFORMED

This section should be completed by the Employer

Please indicate below which background checks you wish to have Foley Carrier Services LLC. perform:

<input type="checkbox"/> Safety Performance History Inquiry (Included)	<input type="checkbox"/> Criminal Report (Call for pricing)
<input type="checkbox"/> DQF Annual Motor Vehicle Report (Included)	<input type="checkbox"/> National Criminal & Sex Offender Registry Report (Call for pricing)
<input type="checkbox"/> Drug & Alcohol Inquiry Only (Call for pricing)	<input type="checkbox"/> Social Security Number to confirm SSN & provides previous addresses (Call for pricing)
<input type="checkbox"/> References (Call for pricing)	<input type="checkbox"/> Education Verification (Call for pricing)
<input type="checkbox"/> Worker's Compensation Claim Report (Call for pricing)	<input type="checkbox"/> Motor Vehicle Report ONLY (Call for pricing)

The receipt of certain background information on an individual involves specific duties and obligations under the Fair Credit Reporting Act. The individual about whom background information is being requested MUST sign this Disclosure and Release.

Any person who knowingly and willfully obtains a consumer report under false pretenses, or for reasons other than employment purposes, may face criminal prosecution.

Employer Authorization (Signature)	Title	Date
Company Name		Client Code

APPLICANT AUTHORIZATION

This section should be complete by the Applicant

Applicant Profile					
Applicant Name: <u>Herton Washington</u>			Social Security Number: <u>25-98-0500</u>		
Date of Application: <u>8/20/17</u>			Driver's License Number: <u>W-635465-298-086</u>		
License Expiration Date: <u>2/1/22</u>			Date of Birth: <u>2-1-76</u>		
Address 1: <u>1000 Willow Bend Dr.</u>			Address 2:		
City: <u>Edgewood Md.</u>	State: <u>Md.</u>	Zip: <u>21040</u>	Telephone: <u>(443) 866-5919</u>		

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED BY FOLEY CARRIER SERVICES LLC. WITH REGARD TO THIS INQUIRY TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I authorize Foley Carrier Services LLC. and their agents to conduct the background investigations indicated above, in conjunction with my current or prospective employer's service contract with Foley Carrier Services, LLC. I understand that these background checks may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, alcohol and controlled substances testing history, etc. I further understand that such reports may contain public record information concerning my driving record, worker's compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records. Information may also be obtained from Foley Carrier Services LLC and their agents concerning previous driving record requests made by others from such state agencies, and state provided driving records. All information obtained will be provided to my current or prospective employer and used for employment purposes only.

This authorization shall remain on file and shall serve as ongoing authorization for the above named employer to procure motor vehicle reports at any time during my employment (or contract) period.

<u>Herton Washington</u> Applicant Authorization (Signature)	SIGN HERE <u>8/20/17</u> Date
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APPLICATION FOR EMPLOYMENT

GREEN/FORM NO.

**DQF
1**

Have all driver-applicants complete this form before driving a commercial motor vehicle.

In compliance with Federal and State equal opportunity employment laws, qualified applicants are considered for all positions without regard to race, religion, color, gender, national origin, age, marital status, or non-job related disability. Please complete both sides of this application thoroughly. Attach additional sheets if more room is required for details.

To be completed by Employer:

Motor Carrier:
Address:

To be completed by Applicant:

Applicant's Name: <u>Heaton H. Washington</u>	Date of Application: <u>8/20/17</u>
Current Address: <u>1000 Willow Bend drive Edgemoor Md.</u>	Social Security No.: <u>215-98-0500</u>
Length of time at this address: <u>Over 15 years</u>	Date of Birth: <u>2/1/76</u>
	Telephone No.: <u>(443) 866-5919</u>

PREVIOUS ADDRESSES FOR LAST THREE YEARS (MOST RECENT FIRST)

Street	City	State/Zip	How long	Additional Information Attached
				<input type="checkbox"/>

LIST ALL UNEXPIRED LICENSES AND/OR PERMITS

State	Number	Expiration Date	Additional Information Attached
<u>Maryland</u>	<u>W-635-465-298-086</u>	<u>2/1/22</u>	<input type="checkbox"/>

LIST THE NATURE AND EXTENT OF YOUR EXPERIENCE OPERATING DIFFERENT TYPES OF MOTOR VEHICLES (E.G. BUSES, TRUCKS & TRAILERS)

Type	Experience in Years and / or Miles Driven	Additional Information Attached
<u>Tractor Trailer</u>	<u>Over 15 years</u>	<input type="checkbox"/>
<u>Straight Trucks</u>	<u>Over 7 years</u>	

LIST ALL MOTOR VEHICLE ACCIDENTS IN WHICH YOU WERE INVOLVED DURING THE LAST THREE YEARS

DATE	CITY/STATE	NATURE OF ACCIDENT	FATALITIES	INJURIES

☒ Check here to certify that you have had no accidents in the last three years

LIST ALL VIOLATIONS (OTHER THAN PARKING) FOR WHICH YOU WERE CONVICTED OR FORFEITED BOND / COLLATERAL DURING THE LAST THREE YEARS

DATE	CITY/STATE	CHARGE	PENALTY
<u>2/26/15</u>	<u>Becks Co. Pa.</u>	<u>Driving too Fast for Condition</u>	<u>Fine</u>

☐ Check here to certify that no convictions or bond forfeitures have occurred

DQF 1 - APPLICATION FOR EMPLOYMENT

Retain for 3 years after ceasing duties

APPLICATION FOR EMPLOYMENT

PLEASE DETAIL THE FACTS AND CIRCUMSTANCES OF ANY DENIAL, REVOCATION, OR SUSPENSION OF ANY LICENSE, PERMIT, OR PRIVILEGE TO OPERATE A MOTOR VEHICLE:

☒ Check here to certify that no such denial, revocation or suspension has occurred

EMPLOYMENT HISTORY

Please complete all information regarding prior employers during the last three years. If you are applying to operate a Commercial Motor Vehicle (GVWR of 10,001 lbs. or more, ability to transport 8 or more people, or any vehicle requiring placarding for hazardous materials), please include complete information regarding prior employers for the last 10 years for whom you operated such vehicles. Please start with your most recent prior employer (Use additional sheets if necessary).

Employer Name: <u>ASAP AUTO</u>	Employed From: <u>06 / 2018</u> To: <u>08 / 2017</u>
Address: <u>24 Middle Wallop Rd. - Bag De</u>	Position: <u>Commercial Driver</u>
Contact: <u>Lawrence</u> Phone: <u>(443) 615-8161</u>	Salary: <u>\$1200 / week</u>
Reason for Leaving: <u>Seeking Local Work</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name: <u>Moral Transportation</u>	Employed From: <u>08 / 10</u> To: <u>05 / 12</u>
Address: <u>5700 Montrose Dr. Kilken Tx.</u>	Position: <u>Commercial Driver</u>
Contact: <u>Mr. Blackburn</u> Phone: <u></u>	Salary: <u>\$800 / week</u>
Reason for Leaving: <u>Family Emergency</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name: <u>Transportation Made Simple</u>	Employed From: <u>06 / 06</u> To: <u>04 / 09</u>
Address: <u>6501 Riverview Ave. Dundalk Md.</u>	Position: <u>Commercial Driver</u>
Contact: <u>Paul Jefferey</u> Phone: <u>(410) 461-8131</u>	Salary: <u>\$800 / week</u>
Reason for Leaving: <u>Lead-off</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

OFFICE USE ONLY

<input type="checkbox"/> Applicant Hired	Date:	Start Date:	Authorized by:
<input type="checkbox"/> Rejected for reasons of:			
<input type="checkbox"/> Date of Termination of Employment:	Authorized by:		
<input type="checkbox"/> Dismissed	<input type="checkbox"/> Quit	<input type="checkbox"/> Other:	
Reason:			

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.

Applicant Signature: [Signature]

SIGN HERE

Date: 8/20/17

RECEIPT OF DRIVER'S RIGHTS

PURPLE/FORM NO.

**SPH
1**

Have each driver-applicant sign this form before you accept his/her employment application.

Employers who are regulated by the Federal Motor Carrier Safety Administration (FMCSA) must expressly notify an applicant, who has been employed by a Department of Transportation-regulated employer during the preceding three years, that the applicant has certain rights regarding the investigative information that will be provided by his/her previous employer(s). After providing the driver-applicant with a written copy of these rights, use this form to obtain his/her signature and retain the top copy of this 2-part form. Give the bottom copy to the applicant. By regulation you must inform the driver of his/her rights **before** accepting the driver's application for employment.

DRIVER REVIEW AND RECEIPT

☒ I acknowledge that Roy Solomon Foley has provided me with written instructions regarding my rights as defined in **Part 391.23(i)-(j)** of the Federal Motor Carrier Safety Regulations. I have reviewed these materials which include information on the following:

- ☒ **Right to Review Information** – I have the right to review the information provided by my previous DOT-regulated employer(s).
- ☒ **Right to Request Corrections** – I have the right to request corrections to information that my previous DOT-regulated employer(s) provides, which I believe contains errors.
- ☒ **Right to Rebut Information** – I have the right to rebut the information provided by my previous DOT-regulated employer(s).

Benton Worthington
Driver's Full Name

[Signature] **SIGN HERE**
Driver's Signature

8/20/17
Date

[Signature] **SIGN HERE**
Supervisor/Authorized Motor Carrier Representative Signature

Date

Employer Keeps Original, Provides Scan or Copy to Applicant

SAFETY PERFORMANCE HISTORY INVESTIGATION

GREEN/FORM NO.

**SPH
2/3/R**

Use ONE form to investigate applicant's Safety Performance History (SPH) for EACH employer within the previous three years. Three forms provided, make copies as necessary.

TO BE COMPLETED BY APPLICANT:

As the applicant, my signature authorizes you, as my previous employer, to release the requested information to Foley Carrier Services, LLC., the service vendor used by my prospective employer,

Applicant's Name: KENTON WORTHINGTON Social Security Number: 215 980 500 Client Code: _____

Applicant's Signature: _____ Previous Employer: ASAP AUTO

TO BE COMPLETED BY PREVIOUS EMPLOYER:

FMCSA regulations require this SPH investigation. Please complete the requested information, using additional paper if necessary. If you have no information to report, please indicate so in the appropriate section. Email completed information to: BSS@FoleyServices.com or fax to: (860) 913-2452.

Verification of Employment

Applicant was employed with this company from: 06/1/201 to: 8/22/17

Position: OTR DRIVER Position required a Commercial Drivers License? ☐ Yes ☒ No

Accident Information

☒ No accident information to report (as defined by Part 390.5)

Date of accident: _____ City or Town (most near) and State: _____ Number of fatalities: _____ Number of Injuries: _____

Release of hazardous materials? ☐ Yes ☒ No (Not including fuel spilled from the fuel tanks of vehicles involved in the accident)

Additional information about the accident: _____

Attach additional sheets if necessary and additional accident information as required pursuant to your internal policies.

Prohibited Drug and Alcohol Testing Information

☐ Individual was not in a safety-sensitive position subject to the Part 40 regulations while in our employment
☒ No prohibited drug and/or alcohol conduct to report

If the driver engaged in prohibited drug and/or alcohol conduct, **as defined by Part 40 and/or Part 382 only**, during the previous three years, answer the questions below.

During the previous three years did the driver:

Have an alcohol test result with an alcohol concentration of 0.04 or higher?

☐ Yes ☒ No

Have a verified positive drug test result?

☐ Yes ☒ No

Refuse to be tested (this includes receiving a verified adulterated or substituted drug test result)?

☐ Yes ☒ No

Have a violation of any of the other drug and/or alcohol testing prohibitions?

☐ Yes ☒ No

If **yes** to any of the above, did the driver:

Comply with the recommendations prescribed by a Substance Abuse Professional (SAP) pursuant to Part 40, while in your employment?

☐ Yes ☒ No

Successfully complete the return to duty program while in your employment?

☐ Yes ☒ No

Attach additional documentation, if available, to verify the individual's successful completion of the return to duty process.

Previous Employer Contact Information

Part 391.23 requires a previous employer who is regulated by the Dept. of Transportation to provide a specific contact name when responding to a Safety Performance History Inquiry. The driver may choose to contact you regarding the information you provide.

Previous Employer Contact Name: Lawrence

Title: Supervisor

Telephone: 443 613 8461

Fax: _____

Mailing Address: 24 Maple Way

Date Released: 8-23-17

Signature of Company Official releasing this information: _____

SIGN HERE

SAFETY PERFORMANCE HISTORY INVESTIGATION

Use ONE form to investigate applicant's Safety Performance History (SPH) for EACH employer within the previous three years. Three forms provided, make copies as necessary.

TO BE COMPLETED BY APPLICANT:

As the applicant, my signature authorizes you, as my previous employer, to release the requested information to Foley Carrier Services, LLC., the service vendor used by my prospective employer,

Applicant's Name: _____ Social Security Number: _____ Client Code: _____

Applicant's Signature: _____ Previous Employer: _____

TO BE COMPLETED BY PREVIOUS EMPLOYER:

FMCSA regulations require this SPH investigation. Please complete the requested information, using additional paper if necessary. If you have no information to report, please indicate so in the appropriate section. Email completed information to: BSS@FoleyServices.com or fax to: (860) 913-2452.

Verification of Employment

Applicant was employed with this company from: ____/____/____ to: ____/____/____

Position: _____ Position required a Commercial Drivers License? ☐ Yes ☐ No

Accident Information

☐ No accident information to report (as defined by Part 390.5)

____/____/____ City or Town (most near) and State Number of fatalities Number of Injuries

Release of hazardous materials? ☐ Yes ☐ No (Not including fuel spilled from the fuel tanks of vehicles involved in the accident)

Additional information about the accident: _____

Attach additional sheets if necessary and additional accident information as required pursuant to your internal policies.

Prohibited Drug and Alcohol Testing Information

☐ Individual was not in a safety-sensitive position subject to the Part 40 regulations while in our employment
☐ No prohibited drug and/or alcohol conduct to report

If the driver engaged in prohibited drug and/or alcohol conduct, **as defined by Part 40 and/or Part 382 only**, during the previous three years, answer the questions below.

During the previous three years did the driver:

Have an alcohol test result with an alcohol concentration of 0.04 or higher? ☐ Yes ☐ No

Have a verified positive drug test result? ☐ Yes ☐ No

Refuse to be tested (this includes receiving a verified adulterated or substituted drug test result)? ☐ Yes ☐ No

Have a violation of any of the other drug and/or alcohol testing prohibitions? ☐ Yes ☐ No

If **yes** to any of the above, did the driver:

Comply with the recommendations prescribed by a Substance Abuse Professional (SAP) pursuant to Part 40, while in your employment? ☐ Yes ☐ No

Successfully complete the return to duty program while in your employment? ☐ Yes ☐ No

Attach additional documentation, if available, to verify the individual's successful completion of the return to duty process.

Previous Employer Contact Information

Part 391.23 requires a previous employer who is regulated by the Dept. of Transportation to provide a specific contact name when responding to a Safety Performance History Inquiry. The driver may choose to contact you regarding the information you provide.

Previous Employer Contact Name

Title

Telephone

Fax

Mailing Address

SIGN HERE

Signature of Company Official releasing this information

Date Released

SPH 2/3/R - SAFETY PERFORMANCE HISTORY INVESTIGATION

Retain for 3 years after the driver leaves your employment

SAFETY PERFORMANCE HISTORY INVESTIGATION

Use **ONE** form to investigate applicant's Safety Performance History (SPH) for **EACH** employer within the previous three years. Three forms provided, make copies as necessary.

TO BE COMPLETED BY APPLICANT:

As the applicant, my signature authorizes you, as my previous employer, to release the requested information to Foley Carrier Services, LLC., the service vendor used by my prospective employer,

Applicant's Name: _____ Social Security Number: _____ Client Code: _____

Applicant's Signature: _____ Previous Employer: _____

TO BE COMPLETED BY PREVIOUS EMPLOYER:

FMCSA regulations require this SPH investigation. Please complete the requested information, using additional paper if necessary. If you have no information to report, please indicate so in the appropriate section. Email completed information to: BSS@FoleyServices.com or fax to: (860) 913-2452.

Verification of Employment

Applicant was employed with this company from: ____/____/____ to: ____/____/____

Position: _____ Position required a Commercial Drivers License? ☐ Yes ☐ No

Accident Information

☐ No accident information to report (as defined by Part 390.5)

____/____/____ City or Town (most near) and State Number of fatalities Number of Injuries

Release of hazardous materials? ☐ Yes ☐ No (Not including fuel spilled from the fuel tanks of vehicles involved in the accident)

Additional information about the accident: _____

Attach additional sheets if necessary and additional accident information as required pursuant to your internal policies.

Prohibited Drug and Alcohol Testing Information

☐ Individual was not in a safety-sensitive position subject to the Part 40 regulations while in our employment
☐ No prohibited drug and/or alcohol conduct to report

If the driver engaged in prohibited drug and/or alcohol conduct, **as defined by Part 40 and/or Part 382 only**, during the previous three years, answer the questions below.

During the previous three years did the driver:

Have an alcohol test result with an alcohol concentration of 0.04 or higher? ☐ Yes ☐ No

Have a verified positive drug test result? ☐ Yes ☐ No

Refuse to be tested (this includes receiving a verified adulterated or substituted drug test result)? ☐ Yes ☐ No

Have a violation of any of the other drug and/or alcohol testing prohibitions? ☐ Yes ☐ No

If **yes** to any of the above, did the driver:

Comply with the recommendations prescribed by a Substance Abuse Professional (SAP) pursuant to Part 40, while in your employment? ☐ Yes ☐ No

Successfully complete the return to duty program while in your employment? ☐ Yes ☐ No

Attach additional documentation, if available, to verify the individual's successful completion of the return to duty process.

Previous Employer Contact Information

Part 391.23 requires a previous employer who is regulated by the Dept. of Transportation to provide a specific contact name when responding to a Safety Performance History Inquiry. The driver may choose to contact you regarding the information you provide.

Previous Employer Contact Name

Title

Telephone

Fax

Mailing Address

SIGN HERE

Signature of Company Official releasing this information

Date Released

SPH 2/3/R - SAFETY PERFORMANCE HISTORY INVESTIGATION

Retain for 3 years after the driver leaves your employment

Vehicle Safety Policy

The safety of our employees who operate company provided vehicles is of primary importance to ROY SALMON TRUCKING LLC. As a driver of a fleet vehicle, your attitude, driving habits and road courtesy are a direct reflection on the organization. Therefore all drivers shall support and abide by the rules and procedures set forth in this policy.

ROY SALMON TRUCKING LLC will:

- Provide vehicles which meet all federally mandated safety requirements and maintain those vehicles in a safe operating condition
- Provide a vehicle operator manual to all drivers when they are assigned a company vehicle
- Provide auto insurance for each leased vehicle

THE DRIVER will:

- Always operate the vehicle in a safe manner
- All drivers will be held responsible for all damages done to the trucks and trailers due to the negligence of the driver and damages that is beyond normal wear or tear
- Ensure that all occupants of the vehicle wear safety belts at all times when the vehicle is in use and appropriate attire in all facilities.
- Never operate the vehicle while impaired
- Inspect the vehicle to ensure the lights and signals are working properly and the tires are properly inflated
- Ensure all scheduled maintenance is performed in a timely manner and any repairs which are needed are reported immediately
- Report any accident in which you are involved to the proper authority
- Never allow anyone who is not an employee of the ROY SALMON TRUCKING LLC drive the vehicle

DISTRACTED DRIVING /CELLULAR PHONE USE

ROY SALMON TRUCKING LLC prohibits the use of hand-held cellular phones while operating a ROY SALMON TRUCKING LLC provided vehicle. ROY SALMON TRUCKING LLC also prohibits under all circumstances sending or reading emails, text messages from cellular phones, pagers or other devices. There are many States/Provinces that have banned hand-held cell phones and implemented hands-

Employer and/or Third Party		INTERCEPT CORPORATION
Name:	<i>Verton H. Worthington</i>	1700 42nd St. S, Suite 2000
Street Address:	<i>1000 Willow Bend Dr</i>	Fargo, ND 58103
City, State, Zip:	<i>Edgewood Md. 21040</i>	
Telephone:	<i>(443) 826-5919</i>	
Fax Number:		

**Authorization for Debit and Credit
Electronic Funds Transfers**

I hereby authorize on this 20th day of August, 2017 my employer and/or third party as referred to here within, and their agents including Intercept Corporation (IC), to initiate electronic withdrawals and/or deposits to the bank account shown below. I understand that adjustment and/or reversing entries may be made to this account to insure an accurate and balanced accounting of all transactions. This authorization will remain in effect until;

- a) I notify my Bank and IC in writing to terminate this agreement and give the Bank and IC reasonable time to terminate this agreement,
- b) The Bank, third party/employer, and/or IC have sent me five (5) business days advance written notice of the Bank's and/or IC's termination of this Agreement

I understand that any cancellation in writing will become effective no earlier than five (5) business days after the day the last transaction has cleared and there are no outstanding balances to the account.

I UNDERSTAND THAT INTERCEPT CORPORATION PROVIDES ELECTRONIC FUND TRANSFER SERVICES TO THIRD PARTIES AND/OR MY EMPLOYER. THE FUNDS TO BE TRANSFERRED MUST BE COLLATERALLY FUNDED AND ARE FULLY GUARANTEED BY MY EMPLOYER AND/OR MYSELF. IN THE EVENT THE FUNDING FOR A TRANSFER IS RETURNED FOR ANY REASON OR INTERCEPT HAS BEEN PROVIDED INCORRECT INFORMATION AND/OR HAS ERRONEOUSLY TRANSFERRED FUNDS TO MY ACCOUNT, I AUTHORIZE INTERCEPT CORPORATION TO WITHDRAW/REVERSE FROM MY ACCOUNT THE AMOUNT OF FUNDS TRANSFERRED IN ERROR. I ALSO UNDERSTAND THAT IC MAY WITHDRAW AND/OR DEPOSIT TO MY ACCOUNT VARIOUS FUNDS REGARDING MY PARTICIPATION IN A FLEXIBLE BENEFIT/CAFETERIA PLAN/ERISA PLAN. I HEREBY HOLD INTERCEPT HARMLESS FOR TRANSFERRING ANY FUNDS DESIGNATED FOR FLEX BENEFITS UPON THE DIRECTION OF MY EMPLOYER OR PROCESSOR, AND THAT MY REMEDY FOR ANY ERRONEOUS TRANSFERS IS SOLELY AGAINST THE PROCESSOR AND/OR MY EMPLOYER AND THAT I WILL HOLD HARMLESS INTERCEPT FROM ANY LIABILITY AND DAMAGES RESULTING THEREFROM. I UNDERSTAND, AGREE, AND ACKNOWLEDGE THAT AS PART OF THE ACH PROCESS, ONCE FUNDS ARE DEBITED FROM THE BANK ACCOUNT SHOWN BELOW PURSUANT TO THIS AGREEMENT, SUCH FUNDS SHALL BE PLACED IN ONE OR MORE IC ACCOUNTS AT IC'S BANK AND THAT IC SHALL BE THE ONLY ENTITY AUTHORIZED ON SUCH ACCOUNTS. I FURTHER ACKNOWLEDGE THAT SUCH IC ACCOUNTS SHALL BE SUBJECT TO SETOFF BY IC'S BANK.





10124584

10124584

4946287

SPECIMEN ID NO.

4946287

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

LAB ACCESSION NO.

A. Employer Name, Address, I.D. No.
 ROY SALMON TRUCKING
 ROY SALMON
 9737 EUSTICE ROAD
 RANDALLSTOWN MD 21133
 PH: 443-629-4648 FAX: --
B. MRO Name, Address, Phone No. and Fax No.
 FREDERICK J POPE, MD, MRO
 FOLEY HRD SERVICES
 140 HUYSHOPE AVE
 HARTFORD CT 06106
 PH: 860-815-0825 FAX: 860-920-5260
C. Donor SSN or Employee I.D. No.

215 95 6526

D. Specify Testing Authority: ☐ HHS ☐ NRC ☒ DOT - Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG**E. Reason for Test:** ☒ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____**F. Drug Tests to be Performed:** ☐ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify) _____

45304H DOT DRUG PANEL W/TS

G. Collection Site Name:**Collection Site Code:**
 Address: 410 687 6467
 City, State and Zip: 410 687 7261

Collector Phone No.:

Collector Fax No.:

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.
 Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark: Collection: ☒ Split ☐ Single ☐ None Provided, Enter Remark: ☐ Observed, (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)**STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY**

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed, and released to the Delivery Service noted in accordance with applicable Federal requirements.

SPECIMEN BOTTLE(S) RELEASED TO:

X

☐ Quest Diagnostics Courier☐ FedEx☐ Other

Signature of Collector

(Print) Collector's Name (First, MI, Last)

Date (Mo./Day/Yr.)

Time of Collection

Name of Delivery Service

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X

Signature of Donor

(PRINT) Donor's Name (First, MI, Last)

Date (Mo./Day/Yr.)

Daytime Phone No. (443) 866-5919

Evening Phone No. (443) 866-5919

Date of Birth 2/1/76

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). - DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable Federal requirements, my verification is:

☐ NEGATIVE ☐ POSITIVE for: _____☐ DILUTE☐ REFUSAL TO TEST because - check reason(s) below:☐ ADULTERATED (adulterant/reason): _____☐ SUBSTITUTED☐ OTHER _____☐ TEST CANCELLED

REMARKS: _____

X

Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my verification for split specimen (if tested) is:

☐ RECONFIRMED for: _____☐ FAILED TO RECONFIRM for: _____☐ TEST CANCELLED

REMARKS: _____

X

Signature of Medical Review Officer

(PRINT) Medical Review Officer's Name (First, MI, Last)

Date (Mo./Day/Yr.)