



## INSTRUCTIONS TO DRIVERS

1. Complete the application
  - a. Make sure to include **TEN YEARS** of previous employment history. If you do not have ten years of experience, list the appropriate information (In school, unemployed, etc.). **There may not be any gaps in this time-frame.**
  - b. Double check that you have included a good phone number, so we may reach you with further instructions.
2. If you have an Alaskan CDL, ask Craig Scott for a release, so we can run your motor vehicle record.
3. Complete the PSP Release
4. Complete the top section only of the Safety Performance History Release.
5. Give 2S Transport Office your:
  - a. completed paperwork
  - b. CDL
  - c. social security card
  - d. medical card
  - e. long-form physical. 2S Transport LLC requires a copy of your long form physical. If you don't have one, you can get a copy by contacting whoever performed it or take a new physical. We must have this documentation before you proceed into orientation.
6. Take the pre-employment drug screen (and physical, if needed)
7. Complete the remaining paperwork and submit to the 2S Transport LLC Office.
8. You will receive a few documents at this time and in orientation for your personal reference.

Return  
With  
Application

---

2S Transport LLC will contact you to schedule an orientation date once the required background checks and drug test results have arrived.



## **2S Transport LLC**

**1475 ACR 336 Palestine, TX 75803**

**903-584-3113 Dispatch \* 903-584-3114 Fax**

---

**Owner Operators:**

**I need the following to set up your equipment.**

**To sign on a truck:**

**Cab Card**

**Truck Registration**

**Bobtail Insurance Policy**

**Recent 2290's**

**Truck Inspection**

**If using EIN # for payment, I need a copy of EIN# from the IRS**

**If signing on a trailer:**

**Trailer Registration**

**Trailer Inspection**

***ONE CALL, PROBLEM SOLVED!***



1475 CR 336  
Palestine, Texas 75803  
903-584-3113 (Office)  
903-584-3114 (Fax)

# DRIVER'S APPLICATION FOR EMPLOYMENT

DATE: \_\_\_\_\_

**APPLICANT NAME:** \_\_\_\_\_

In compliance with federal and state equal employment opportunities laws, qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital status, veteran status, non-job related disability or any other protected group status.

**AUTHORIZATION:** I authorize you to make such investigations of my personal, employment, financial, criminal, regulatory or medical history and other related matters as may be necessary in arriving at an employment decision. Generally, inquiries regarding medical history will be made only if and after a conditional offer of employment has been extended. I hereby release employers, schools, health care providers, and other personnel from all liability in responding to inquiries and releasing information in connection with my application. In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of H&S Transportation LP.

**DRIVER'S RIGHTS.** I acknowledge that 2S Transport LLC 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
- Right to Correct Corrections
- Right to Rebut Information

**APPLICANT TO COMPLETE**

Position Applied for: Commercial Truck Driver Social Security Number: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (required for commercial drivers)

Can you provide proof of age?  Yes  No

List your address for the past **THREE** years.

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

How Long? \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Previous Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

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

Have you worked for this company before?  Yes  No

If yes, dates: From: \_\_\_\_\_ To: \_\_\_\_\_

Rate of pay: \$ \_\_\_\_\_ Position: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

Are you employed now?  Yes  No If not, date of separation: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Expected rate of pay? \$ \_\_\_\_\_

Have you ever been bonded?  Yes  No

Name of bonding company: \_\_\_\_\_

Do you have the legal right to work in the United States?  Yes  No

Have you ever been convicted of a felony?  Yes  No

Are you on probation at this time?  Yes  No Charge: \_\_\_\_\_

Can you cross state lines?  Yes  No

Is there any reason you might be unable to perform the functions of the job for which you have applied?

Yes  No

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

## EMPLOYMENT HISTORY

All driver applicants to drive in interstate commerce must provide the following information on all employers during the preceding three years. Be sure to list complete mailing address, street number, city, state and zip code.

Applicants to drive a commercial motor vehicle in intrastate or interstate commerce shall also provide an additional seven years information on those employers for whom the applicant operated such vehicle:

NOTE: List employers in reverse order, starting with the most recent.

### NO GAPS IN TEN YEAR HISTORY

Employer Name: _____	Dates of Employment: _____ to _____
Address: _____	Position Held: _____
City: _____ State: _____	Zip: _____ Salary: _____
Contact Person: _____	Phone Number: _____
Were you subject to the FMCSRs while you were employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was your job designated as a safety-sensitive function in any DOT-regulated mode, subject to the drug and alcohol testing requirements of 49CFR Part 40? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name: _____	Dates of Employment: _____ to _____
Address: _____	Position Held: _____
City: _____ State: _____	Zip: _____ Salary: _____
Contact Person: _____	Phone Number: _____
Were you subject to the FMCSRs while you were employed? Yes <input type="checkbox"/> No	
Was your job designated as a safety-sensitive function in any DOT-regulated mode, subject to the drug and alcohol testing requirements of 49CFR Part 40? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name: _____	Dates of Employment: _____ to _____
Address: _____	Position Held: _____
City: _____ State: _____	Zip: _____ Salary: _____
Contact Person: _____	Phone Number: _____
Were you subject to the FMCSRs while you were employed? Yes <input type="checkbox"/> No	
Was your job designated as a safety-sensitive function in any DOT-regulated mode, subject to the drug and alcohol testing requirements of 49CFR Part 40? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_ Position Held: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Salary: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Were you subject to the FMCSRs while you were employed? Yes  No

Was your job designated as a safety-sensitive function in any DOT-regulated mode, subject to the drug and alcohol testing requirements of 49CFR Part 40?  Yes  No

Employer Name: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_ Position Held: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Salary: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Were you subject to the FMCSRs while you were employed? Yes  No

Was your job designated as a safety-sensitive function in any DOT-regulated mode, subject to the drug and alcohol testing requirements of 49CFR Part 40?  Yes  No

Employer Name: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_ Position Held: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Salary: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Were you subject to the FMCSRs while you were employed? Yes  No

Was your job designated as a safety-sensitive function in any DOT-regulated mode, subject to the drug and alcohol testing requirements of 49CFR Part 40?  Yes  No

Employer Name: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_ Position Held: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Salary: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Were you subject to the FMCSRs while you were employed? Yes  No

Was your job designated as a safety-sensitive function in any DOT-regulated mode, subject to the drug and alcohol testing requirements of 49CFR Part 40?  Yes  No

**ACCIDENT RECORD** for past three years  
 (Attach additional sheet if more space is required). If none, write none.

	Date	Nature of Accident	Fatalities	Injuries	Haz-Mat Spill
Last Accident					
Next Previous					
Next Previous					

**TRAFFIC CONVICTIONS** for past three years, other than parking violations  
 (Attach additional sheet if more space is required). If none, write none.

Date	Location	Charge	Penalty

**EXPERIENCE AND QUALIFICATIONS – DRIVER**

	State	License Number	Type	Expiration
Driver				
Endorsements				

- A. Have you ever been denied a license, permit or privilege to operate a motor vehicle?  
 B. Has any license, permit or privilege ever been suspended or revoked?

If the answer to either A or B is yes, give details below.

**DRIVING EXPERIENCE** (check yes or no)

Class of Equipment	Yes or No	Equipment Type	Dates		Approx. Number Of Miles
			From	To	
Straight Truck					
Tractor and Semi-Trailer					
Trailer – Two Trailers					
Motor Coach / School Bus – 8					
Motor Coach / School Bus – 15+					

List states/regions operated in for the last five years: \_\_\_\_\_

List any safe driving awards you've earned: \_\_\_\_\_

Total years of commercial driving experience: \_\_\_\_\_

**EXPERIENCE AND QUALIFICATIONS – OTHER**

Show any trucking, transportation or other experience that may help in your work for this company:

---

List courses and training other than shown elsewhere in the application:

---

List special equipment or technical materials you can work with (other than already shown)

---

**EDUCATION**

Last school attended and location: (City and State) \_\_\_\_\_

Highest grade completed: \_\_\_\_\_

---

**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.

Applicant's Signature: \_\_\_\_\_

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



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

## IN THE EVENT OF AN ACCIDENT OR EMERGENCY, WHOM SHOULD WE NOTIFY?

Relative (Other than spouse) \_\_\_\_\_  
(Name) (Relationship) (Address)  
\_\_\_\_\_  
(City) (State) (Work telephone) (Home telephone)

Minister: \_\_\_\_\_  
(Name) (Address) (Work telephone) (Home telephone)

Friend: \_\_\_\_\_  
(Name) (Address) (Work telephone) (Home telephone)

Friend: \_\_\_\_\_  
(Name) (Address) (Work telephone) (Home telephone)

## FAMILY INFORMATION

\_\_\_\_\_  
Spouse's Full Name (or former spouse) (Maiden name) (Birthday)  
\_\_\_\_\_  
(Address) (Work telephone) (Home telephone)

Children: \_\_\_\_\_  
(Name) (Date of Birth)  
\_\_\_\_\_  
(Name) (Date of Birth)  
\_\_\_\_\_  
(Name) (Date of Birth)  
\_\_\_\_\_  
(Name) (Date of Birth)  
\_\_\_\_\_  
(Name) (Date of Birth)

## Fair Credit Reporting Act Disclosure Statement

In accordance with the provisions of Section 604(b)(2)(A) of the Fair Credit Reporting Act, Public Law 91-508, as amended by the Consumer Credit Reporting Act of 1996 (Title II, Subtitle D, Chapter I, of Public Law 104-208), you are being informed that reports verifying your previous employment, previous drug and alcohol test results, and your driving record may be obtained on you for employment purposes. These reports are required by Sections 382.413, 391.23, and 391.25 of the Federal Motor Carrier Safety Regulations.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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

# Driver Certification of Compensated Work for Other Entities

Part 395.2 of the Federal Motor Carrier Safety Regulations (FMCSR) defines "on-duty" time. This definition includes "performing any other work in the capacity, employ, or service of a motor carrier" (FMCSR Part 395.2 (8)), AND "performing any compensated work for any non-motor carrier entity" (FMCSR Part 395.2 (9)). In other words, as a driver for a motor carrier you must report all time spent in the performance of work for that motor carrier *in addition to* all time spent working for compensation elsewhere.

If, while you are otherwise considered "off-duty", you are performing compensated work for someone else, these hours must be reported to the company and included in your calculations of hours available to work for the company. Hours worked for which you do not receive compensation, such as volunteer work, do not need to be reported.

Please choose one of the following statements which best describes your current situation:

I am not currently performing any work for any other motor carrier or non-motor carrier entity which is required to be reported.

I am currently performing work for compensation for either a motor carrier or a non-motor carrier entity, as follows: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify with my signature below that I understand my obligation to report all hours worked for other entities for which I receive compensation throughout the course of my association with this company. I further certify that my answer(s) to the above statements are true and I will notify the company in the future when and if the work status I have marked above changes in any way.

\_\_\_\_\_  
*Driver Name (please print)*

\_\_\_\_\_  
*Driver Signature*

\_\_\_\_\_  
*Date*

## CERTIFICATION OF COMPLIANCE WITH DRIVER LICENSE REQUIREMENTS

**MOTOR CARRIER INSTRUCTIONS:** The requirements in Part 383 apply to every driver who operates in intrastate, interstate, or foreign commerce and operates a vehicle weighing 26,001 pounds or more, can transport more than 15 people, or transports hazardous materials that require placarding.

The requirements in Part 391 apply to every driver who operates in interstate commerce and operates a vehicle weighing 10,001 pounds or more, can transport more than 15 people, or transports hazardous materials that require placarding.

**DRIVER REQUIREMENTS:** Parts 383 and 391 of the Federal Motor Carrier Safety Regulations contain some requirements that you as a driver must comply with. These requirements are in effect as of July 1, 1987. They are as follows:

- 1 POSSESS ONLY ONE LICENSE:** you, as a commercial vehicle driver, may not possess more than one motor vehicle operator's license.

If you have more than one license, keep the license from your state of residence and return the additional licenses to the states that issued them. Destroying a license does not close the record in the state that issued it; you must notify the state. If a multiple license has been lost, stolen, or destroyed, close your record by notifying the state of issuance that you no longer want to be licensed by that state.

- 2 NOTIFICATION OF LICENSE SUSPENSION, REVOCATION OR CANCELLATION:** Sections 391.5 (b)(2) and 383.33 of the Federal Motor Carrier Safety Regulations required that you notify your employer the next business day of any revocation or suspension of your driver's license. In addition, Section 383.31 requires that any time you violate a state or local traffic law (other than parking), you must report it within 30 days to your employing motor carrier, and the state that issued your license (if the violation occurs in a state other than the one which issued your license). The notification to both the employer and state must be in writing.

The following license is the only one I will possess:

Driver's License No. \_\_\_\_\_ State \_\_\_\_\_ Exp. Date \_\_\_\_\_

**DRIVER CERTIFICATION:** I certify that I have read and understood the above requirements.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## Drivers Statement of On-Duty Hours

(To be completed upon hire)

**Instructions:** 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 \_\_\_\_\_

Endorsements \_\_\_\_\_

Day	1	2	3	4	5	6	7	
Date								
Hours Worked								<b>Total Hours</b>

I hereby certify that the information given above is current to the best of my knowledge and belief, and that I was last relieved from work at

\_\_\_\_\_ A.M. \_\_\_\_\_  
 \_\_\_\_\_ P.M. on \_\_\_\_\_  
 time Day Month Year

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

\_\_\_\_\_  
 Date

# Certification of a Positive Pre-employment Drug or Alcohol Test Result or Report of a Refusal to Test.

In compliance with the provisions of the Federal Motor Carrier Safety Regulations regarding the Procedures for Transportation Workplace Drug and Alcohol Testing Programs (49 CFR Part 40.25(j)), every person applying for a safety-sensitive position with a Commercial Motor Carrier must answer the following questions:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you ever tested positive on any pre-employment drug 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 during the past two years?    | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever tested positive on any pre-employment 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 during the past two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever refused 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 during the past two years?    | <input type="checkbox"/> | <input type="checkbox"/> |

**If any of the above questions were answered YES, please complete the following:**

Company Name and address for which you applied for, but did not obtain, safety sensitive transportation work:

Company Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zipcode: \_\_\_\_\_  
 Person to contact: \_\_\_\_\_ Telephone Number \_\_\_\_\_  
 Date of Positive Test or Test Refusal: \_\_\_\_\_

Name, address, and telephone number of the Substance Abuse Professional that approved your return to duty:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip code: \_\_\_\_\_  
 Person to contact: \_\_\_\_\_ Telephone Number \_\_\_\_\_

I did not see a Substance Abuse Professional following this event.

**I certify with my signature below that the information above is true and correct. I understand that providing false or misleading information is a serious violation of federal law and, if approved for a driving position, doing so could be cause for the immediate termination of any employment or contractual agreement I may have with the company.**

\_\_\_\_\_  
 (Applicant Signature) (Date) (Applicant Social Security Number)

# RECORD OF VIOLATIONS

Driver's Name \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
(Please Print or Type)

**I. CERTIFICATION OF VIOLATIONS:**

I certify that the following is a true and complete list of traffic violations (other than parking violations) for which I have been convicted or forfeited bond or collateral during the past 12 months.

Date of Conviction	Offense	Location	Type of Vehicle Operated

*If no traffic violations during this period, write "NONE"*

<b>IMPORTANT</b>	<p style="text-align: center;"><b><u>CDL License Information</u></b></p> <p><b>State</b> _____</p> <p><b>Number</b> _____</p> <p><b>Date Expires</b> _____</p>	<b>IMPORTANT</b>
<b>IMPORTANT</b>		<b>IMPORTANT</b>

If no violations are listed above, I certify that I have not been convicted or forfeited bond or collateral on account of any violation required to be listed during the past 12 months.

(Date you sign form)

---

(Date of Certification)

---

(Driver's signature)

H & S Transportation, LP  
 (Motor Carrier's Name)

12212 State Highway 155 North, Palestine, TX 75803  
 (Motor Carrier's Address)

\_\_\_\_\_  
 (Reviewed by: Signature)

\_\_\_\_\_  
 (Title)

FOR OFFICE USE ONLY - Please do not write below this line.

**II. ANNUAL REVIEW OF DRIVING RECORD:**

In accordance with Part § 391.25 of the Federal Motor Carrier Safety Regulations, all information pertaining to the above driver's safety of operation, including the record of violations furnished by the driver pursuant to Part § 391.27 of the Federal Motor Carrier Safety Regulations has been reviewed for the past 12 months.

Driver meets the minimum qualification requirements of the Federal Motor Carrier Safety Regulations

Action(s) taken:

\_\_\_\_\_

H & S Transportation, LP  
 Address)

12212 State Highway 155 North, Palestine, TX 75803  
 (Motor Carrier's Name) (Motor Carrier's

\_\_\_\_\_  
 (Reviewed by: Signature)

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

\_\_\_\_\_  
 (Title)



# RELEASE OF CDL HOLDER'S REPORTED POSITIVE ALCOHOL OR CONTROLLED SUBSTANCE TEST RESULTS



**Use this form to obtain the CDL holder's reported positive alcohol or controlled substance test results information.**

This form should ONLY be used if you wish to inquire whether or not a prospective driver (CDL Holder) has had a positive alcohol or controlled substance test result reported to the Texas Department of Public Safety in compliance with state law.

**THIS FORM IS NOT REQUIRED FOR REPORTING A POSITIVE  
ALCOHOL OR CONTROLLED SUBSTANCE TEST.**

1. This form must be completed in full and include the driver's original signature.  
*(Electronic signatures will not be accepted)*

2. Deliver, mail, Email or FAX the completed form to:

**Texas Department of Public Safety  
Motor Carrier Bureau, MSC #0521  
6200 Guadalupe, Building P  
Austin, Texas 78752-4019 / Facsimile: 512-424-5310  
Email: MCB.VPR@dps.texas.gov**

<input type="checkbox"/>	Check here if CDL Holder is requesting results on self
--------------------------	--

Print Name of CDL Holder	Phone Number
Print full Address, City, State and Zip Code of CDL Holder	Social Security #
Driver License Number of CDL Holder _____ State _____ Date of Birth _____	
authorize release of any and all of CDL holder's reported positive alcohol or controlled substance test results reported under Texas state law to	
Print Motor Carrier's Name	Phone Number
Print full Address, City, State and Zip Code of Motor Carrier	

Signature of Driver  <div style="font-size: 2em; font-weight: bold; margin-top: 10px;">X</div>	Date
--	------

**If you wish to request and receive this information by electronic mail, submit a completed and notarized Electronic Mail Verification Form (MCS-32), available at the following web address: <http://www.dps.texas.gov.htm>.**





# REPORT OF VALID POSITIVE RESULT ON ALCOHOL TEST UNDER TRC 644.252



<b>A. ID</b>	NAME OF MOTOR CARRIER		DATE OF ALCOHOL TEST	
	NAME OF INDIVIDUAL TESTED	SOCIAL SECURITY NUMBER	CDL NUMBER & STATE	BIRTHDATE

## INSTRUCTIONS FOR THE COMPLETION OF THE REPORT OF POSITIVE ALCOHOL TEST UNDER TRC 644.252:

### TO THE MOTOR CARRIER

**B. INSTRUCTIONS**

1. You must complete and sign the "Certificate of Motor Carrier" section.
2. You must attach a legible copy of the completed federal Alcohol Testing Form with the screening and confirmation test results included or affixed. If the donor refused to provide a specimen, you do not need documentation from the Breath Alcohol Technician (BAT).
3. Deliver or mail this form and the supporting documentation to: MCS Section Supervisor, Motor Carrier Bureau, Texas Department of Public Safety, 6200 Guadalupe, MSC# 0521, Austin, Texas 78752-4019.  
**Legible copies may be sent by facsimile /email to 512-424-5310 or [MCB.VPR@dps.texas.gov](mailto:MCB.VPR@dps.texas.gov)**
4. Retain a copy of this form and the completed Alcohol Testing Form in the Motor Carrier records as required by 49 CFR Parts 40 and 382 (or other parts applicable to CDL holders).
5. You must forward this report to the department within **ten** days of receiving the completed test results.

By signing below, I the authorized representative of the Motor Carrier listed above, certify the following:

**C. CERTIFICATE OF MOTOR CARRIER**

1. The Motor Carrier listed above:  Has an in-house drug and alcohol testing program that meets the federal requirements of 49 CFR Parts 40 and 382 (or other parts applicable to CDL holders); **OR**  
 Is a member of a consortium, as defined in 49 CFR 382.107, that provides drug and alcohol testing that meets the federal requirements of 49 CFR Parts 40 and 382 (or other parts applicable to CDL holders).  
**NAME OF CONSORTIUM:** \_\_\_\_\_
2. The individual tested is subject to alcohol testing by the Motor Carrier, and was tested for the following reason:  
 Random  Reasonable Suspicion  Post-Accident  Return to Duty  Follow-up  Pre-employment  
 Other: \_\_\_\_\_; **AND**  
 Had a 0.04 or more breath alcohol level under 49 CFR Parts 40 and 382 (or other parts applicable to CDL holders) (**NOTE:** a copy of the federal Alcohol Testing Form must be provided, with the screening and confirmation test results included or affixed to the federal Alcohol Testing Form); **OR**  
 Refused to submit to an alcohol test (**NOTE: Supporting documents not required**)

**I further certify that I have reviewed the motor carrier's records and that the information contained in this certificate is true and correct to the best of my knowledge.**

PRINTED NAME OF DESIGNATED MOTOR CARRIER REPRESENTATIVE		TELEPHONE NUMBER	
ADDRESS			
SIGNATURE OF DESIGNATED MOTOR CARRIER REPRESENTATIVE <b>X</b>	CITY	STATE	ZIP CODE

**Mail form/attachments to the MCS Supervisor, Motor Carrier Bureau, Texas Department of Public Safety, 6200 Guadalupe, MSC# 0521, Austin, Texas 78752-4019, FAX LEGIBLE copy to 512-424-5310 or email to [MCB.VPR@dps.texas.gov](mailto:MCB.VPR@dps.texas.gov) .**



## REPORT OF VALID POSITIVE RESULT ON DRUG TEST UNDER TRC 644.252



<b>A. ID</b>	NAME OF MOTOR CARRIER		DATE OF DRUG TEST	
	NAME OF INDIVIDUAL TESTED	SOCIAL SECURITY NUMBER	CDL NUMBER & STATE	BIRTHDATE

<b>B. INSTRUCTIONS</b>	<p><b>INSTRUCTIONS FOR THE COMPLETION OF THE REPORT OF POSITIVE DRUG TEST UNDER TRC 644.252: TO THE MOTOR CARRIER</b></p>
	<ol style="list-style-type: none"> <li>1. You must complete and sign the "Certificate of Motor Carrier" section.</li> <li>2. You must attach a legible copy of the signed the Federal Drug Testing, Custody and Control Form (with at least steps one through six completed) <u>or</u> the MRO's signed report of positive controlled substance result. If the donor refused to provide a specimen, you do not need documentation from the MRO.</li> <li>3. Deliver or mail this form and the supporting documentation to: MCS Section Supervisor, Motor Carrier Bureau, Texas Department of Public Safety, 6200 Guadalupe, MSC# 0521, Austin, Texas 78752-4019. <b>Legible copies</b> may be sent by facsimile /email to 512-424-5310 or <a href="mailto:MCB.VPR@dps.texas.gov">MCB.VPR@dps.texas.gov</a></li> <li>4. Retain a copy of this form and the Federal Drug Testing, Custody and Control Form and/or the MRO's report of positive controlled substance result in the Motor Carrier records as required by 49 CFR, Parts 40 and 382 (or other parts applicable to CDL holders).</li> <li>5. You must forward your report to the department within <b>ten</b> days of receiving the completed test results.</li> </ol>

<b>C. CERTIFICATE OF MOTOR CARRIER</b>	<p>By signing below, I the authorized representative of the Motor Carrier listed above, certify the following:</p>					
	<ol style="list-style-type: none"> <li>1. The Motor Carrier listed above: <input type="checkbox"/> Has an in-house drug and alcohol testing program that meets the federal requirements of 49 CFR Parts 40 and 382 (or other parts applicable to CDL holders); <b>OR</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Is a member of a consortium, as defined in 49 CFR 382.107, that provides drug and alcohol testing that meets the federal requirements of 49 CFR Parts 40 and 382 (or other parts applicable to CDL holders). <b>NAME OF CONSORTIUM:</b> _____</li> </ul> </li> <li>2. The individual tested is subject to drug testing by the Motor Carrier, and was tested for the following reason: <ul style="list-style-type: none"> <li><input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Post-Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up <input type="checkbox"/> Pre-employment</li> <li><input type="checkbox"/> Other: _____; <b>AND</b></li> <li><input type="checkbox"/> Tested positive for a prohibited drug under 49 CFR Parts 40 and 382 (or other parts applicable to CDL holders) (<b>NOTE:</b> a copy of the federal drug testing custody and control form or the MRO's report of positive controlled substance result must be attached); <b>OR</b></li> <li><input type="checkbox"/> Refused to submit to a controlled substance test (<b>NOTE: Supporting documents not required</b>)</li> </ul> </li> </ol>					
	<p><b>I further certify that I have reviewed the motor carrier's records and that the information contained in this certificate is true and correct to the best of my knowledge.</b></p>					
	<table style="width: 100%;"> <tr> <td style="width: 75%;">PRINTED NAME OF DESIGNATED MOTOR CARRIER REPRESENTATIVE</td> <td style="width: 25%;">TELEPHONE NUMBER</td> </tr> <tr> <td colspan="2">ADDRESS</td> </tr> <tr> <td>SIGNATURE OF DESIGNATED MOTOR CARRIER REPRESENTATIVE <b>X</b></td> <td>CITY STATE ZIP CODE</td> </tr> </table>	PRINTED NAME OF DESIGNATED MOTOR CARRIER REPRESENTATIVE	TELEPHONE NUMBER	ADDRESS		SIGNATURE OF DESIGNATED MOTOR CARRIER REPRESENTATIVE <b>X</b>
PRINTED NAME OF DESIGNATED MOTOR CARRIER REPRESENTATIVE	TELEPHONE NUMBER					
ADDRESS						
SIGNATURE OF DESIGNATED MOTOR CARRIER REPRESENTATIVE <b>X</b>	CITY STATE ZIP CODE					

**Mail form/attachments to the MCS Supervisor, Motor Carrier Bureau, Texas Department of Public Safety, 6200 Guadalupe, MSC# 0521, Austin, Texas 78752-4019, FAX LEGIBLE copy to 512-424-5310 or email to [MCB.VPR@dps.texas.gov](mailto:MCB.VPR@dps.texas.gov) .**

**THE BELOW DISCLOSURE AND AUTHORIZATION LANGUAGE IS FOR MANDATORY USE BY ALL ACCOUNT HOLDERS**

**IMPORTANT DISCLOSURE  
REGARDING BACKGROUND REPORTS FROM THE PSP Online Service**

In connection with your application for employment with 2 S Transport (“Prospective Employer”), Prospective Employer, its employees, agents or contractors may obtain one or more reports regarding your driving, and safety inspection history from the Federal Motor Carrier Safety Administration (FMCSA).

When the application for employment is submitted in person, if the Prospective Employer uses any information it obtains from FMCSA in a decision to not hire you or to make any other adverse employment decision regarding you, the Prospective Employer will provide you with a copy of the report upon which its decision was based and a written summary of your rights under the Fair Credit Reporting Act before taking any final adverse action. If any final adverse action is taken against you based upon your driving history or safety report, the Prospective Employer will notify you that the action has been taken and that the action was based in part or in whole on this report.

When the application for employment is submitted by mail, telephone, computer, or other similar means, if the Prospective Employer uses any information it obtains from FMCSA in a decision to not hire you or to make any other adverse employment decision regarding you, the Prospective Employer must provide you within three business days of taking adverse action oral, written or electronic notification: that adverse action has been taken based in whole or in part on information obtained from FMCSA; the name, address, and the toll free telephone number of FMCSA; that the FMCSA did not make the decision to take the adverse action and is unable to provide you the specific reasons why the adverse action was taken; and that you may, upon providing proper identification, request a free copy of the report and may dispute with the FMCSA the accuracy or completeness of any information or report. If you request a copy of a driver record from the Prospective Employer who procured the report, then, within 3 business days of receiving your request, together with proper identification, the Prospective Employer must send or provide to you a copy of your report and a summary of your rights under the Fair Credit Reporting Act.

Neither the Prospective Employer nor the FMCSA contractor supplying the crash and safety information has the capability to correct any safety data that appears to be incorrect. You may challenge the accuracy of the data by submitting a request to <https://dataqs.fmcsa.dot.gov>. If you challenge crash or inspection information reported by a State, FMCSA cannot change or correct this data. Your request will be forwarded by the DataQs system to the appropriate State for adjudication.

Any crash or inspection in which you were involved will display on your PSP report. Since the PSP report does not report, or assign, or imply fault, it will include all Commercial Motor Vehicle (CMV) crashes where you were a driver or co-driver and where those crashes were reported to FMCSA, regardless of fault. Similarly, all inspections, with or without violations, appear on the PSP report. State citations associated with Federal Motor Carrier Safety Regulations (FMCSR) violations that have been adjudicated by a court of law will also appear, and remain, on a PSP report.

The Prospective Employer cannot obtain background reports from FMCSA without your authorization.

**AUTHORIZATION**

If you agree that the Prospective Employer may obtain such background reports, please read the following and sign below:

I authorize 2 S Transport (“Prospective Employer”) to access the FMCSA Pre-Employment Screening Program (PSP) system to seek information regarding my commercial driving safety record and information regarding my safety inspection history. I understand that I am authorizing the release of safety performance information including crash data from the previous five (5) years and inspection history from the previous three (3) years. I understand and acknowledge that this release of information may assist the Prospective Employer to make a determination regarding my suitability as an employee.

I further understand that neither the Prospective Employer nor the FMCSA contractor supplying the crash and safety information has the capability to correct any safety data that appears to be incorrect. I understand I may challenge the accuracy of the data by submitting a request to <https://dataqs.fmcsa.dot.gov>. If I challenge crash or inspection information reported by a State, FMCSA cannot change or correct this data. I understand my request will be forwarded by the DataQs system to the appropriate State for adjudication.

I understand that any crash or inspection in which I was involved will display on my PSP report. Since the PSP report does not report, or assign, or imply fault, I acknowledge it will include all CMV crashes where I was a driver or co-driver and where those crashes were reported to FMCSA, regardless of fault. Similarly, I understand all inspections, with or without violations, will appear

on my PSP report, and State citations associated with FMCSR violations that have been adjudicated by a court of law will also appear, and remain, on my PSP report. I have read the above Disclosure Regarding Background Reports provided to me by Prospective Employer and I understand that if I sign this Disclosure and Authorization, Prospective Employer may obtain a report of my crash and inspection history. I hereby authorize Prospective Employer and its employees, authorized agents, and/or affiliates to obtain the information authorized above.

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

Signature

\_\_\_\_\_

Name (Please Print)

NOTICE: This form is made available to monthly account holders by NIC on behalf of the U.S. Department of Transportation, Federal Motor Carrier Safety Administration (FMCSA). Account holders are required by federal law to obtain an Applicant's written or electronic consent prior to accessing the Applicant's PSP report. Further, account holders are required by FMCSA to use the language contained in this Disclosure and Authorization form to obtain an Applicant's consent. The language must be used in whole, exactly as provided. Further, the language on this form must exist as one stand-alone document. The language may NOT be included with other consent forms or any other language.

*LAST UPDATED 12/22/2015*



# 2S Transport LLC

1475 ACR 336 Palestine, TX 75803

903-584-3113 Dispatch \* 903-584-3114 Fax

## SAFETY PERFORMANCE HISTORY RECORDS REQUEST

### PART 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 3 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from \_\_\_\_\_ (employment application date)

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

Attention: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

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.

Prospective employer's fax number: \_\_\_\_\_

Prospective employer's email address: \_\_\_\_\_

Applicant's Signature Date \_\_\_\_\_

This information is being requested in compliance with §40.25(g) and 391.23.

### PART 2: TO BE COMPLETED BY PREVIOUS EMPLOYER

#### ACCIDENT HISTORY

The applicant named above was employed by us. Yes No

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

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

2. Reason for leaving your employ: Discharged Resignation Lay Off Military Duty

If there is no safety performance history to report, check here, sign below and return.

ACCIDENTS: 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 above, or check here if there is no accident register data for this driver.

Date Location # Injuries # Fatalities Hazmat Spill

1. \_\_\_\_\_

2. \_\_\_\_\_

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

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

Any other remarks: \_\_\_\_\_

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

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

**ONE CALL, PROBLEM SOLVED!**



# 2S Transport LLC

1475 ACR 336 Palestine, TX 75803

903-584-3113 Dispatch \* 903-584-3114 Fax

### PREVIOUS EMPLOYER – COMPLETE PAGE 2 PART 3 PART 3: TO BE COMPLETED BY PREVIOUS EMPLOYER DRUG AND ALCOHOL HISTORY

If driver was not subject to Department of Transportation testing requirements while employed by this employer, please check here, fill in the dates of employment from \_\_\_\_\_ to \_\_\_\_\_, complete bottom of Part 3, sign, and return.

Driver was subject to Department of Transportation testing requirements from \_\_\_\_\_ to \_\_\_\_\_.

1. Has this person had an alcohol test with the result of 0.04 or higher alcohol concentration?

YES NO

2. Has this person tested positive or adulterated or substituted a test specimen for controlled substances?

YES NO

3. Has this person refused to submit to a post-accident, random, reasonable suspicion, or follow-up alcohol or controlled substance test?

YES NO

4. Has this person committed other violations of Subpart B of Part 382, or Part 40?

YES NO

5. If this person has violated a DOT drug and alcohol regulation, did this person complete a SAP-prescribed rehabilitation program in your employ, including return-to-duty and follow-up tests? If yes, please send documentation back with this form.

YES NO

6. For a driver who successfully completed a SAP's rehabilitation referral and remained in your employ, did this driver subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refuse to be tested?

YES NO

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

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

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

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

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

Part 3 Completed by (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

### PART 4a: TO BE COMPLETED BY PROSPECTIVE EMPLOYER

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

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

### PART 4b: TO BE COMPLETED BY PROSPECTIVE EMPLOYER

Complete below when information is obtained.

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

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

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

### INSTRUCTIONS TO COMPLETE THE SAFETY PERFORMANCE HISTORY RECORDS REQUEST

PAGE 1 PART 1: Prospective Employer  Complete the information required in this section  Sign and date  Submit to the Prospective Employer

PAGE 2 PART 4a: Prospective Employer  Complete the information  Send to Previous Employer

PAGE 1 PART 2: Previous Employer  Complete the information required in this section  Sign and date  Turn form over to complete

### SIDE 2 SECTION 3

PAGE 2 PART 3: Previous Employer  Complete the information required in this section  Sign and date  Return to Prospective

Employer PAGE 2 PART 4b: Prospective Employer  Record receipt of the information  Retain the form

**ONE CALL, PROBLEM SOLVED!**



# 2S Transport LLC

1475 ACR 336 Palestine, TX 75803

903-584-3113 Dispatch \* 903-584-3114 Fax

## RECORDS REQUEST FOR DRIVER/APPLICANT SAFETY PERFORMANCE HISTORY

This request is made by the driver/applicant in compliance with the Department of Transportation regulations. §391.23(i)(2) Drivers who have previous Department of Transportation regulated employment history in the preceding three years, and wish to review previous employer-provided investigative information must submit a written request to the prospective employer, which may be done at any time, including when applying, or as late as thirty (30) days after being employed or being notified of denial of employment. The prospective employer must provide this information to the applicant within five (5) business days of receiving the written request. If the prospective employer has not yet received the requested information from the previous employer(s), then the five-business-days deadline will begin when the prospective employer receives the requested safety-performance history information. If the driver has not arranged to pick up or receive the requested records within thirty (30) days of the prospective employer making them available, the prospective motor carrier may consider the driver to have waived his/her request to review the records.

### PART 1: COMPLETED BY THE DRIVER/APPLICANT

TO:

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

Street/P.O. Box: \_\_\_\_\_

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

FROM:

Driver/Applicant: \_\_\_\_\_ Social Security/I.D. # \_\_\_\_\_

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

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

I am submitting this written request to obtain copies of my Department of Transportation Safety Performance History for the preceding three years. I understand, for records requested from a prospective employer, that I must arrange to pick up or receive the requested records within thirty (30) days of the records being made available or I have waived my request to review the records.

This information should be: sent to me at the above address.

I will arrange to pick up.

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

M D Y

### PART 2: COMPLETED BY THE PROSPECTIVE EMPLOYER

The information must be provided to the applicant within five (5) business days of receiving the written request. If the prospective employer has not yet received the requested information from the previous employer(s), then the five-businessdays deadline will begin when the prospective employer receives the requested safety performance history information.

Information supplied to:

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

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

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

Comments: \_\_\_\_\_

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

Signature/person providing information Telephone # M D Y \_\_\_\_\_ Release Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ONE CALL, PROBLEM SOLVED!**



## 2S Transport LLC

1475 ACR 336 Palestine, TX 75803

903-584-3113 Dispatch \* 903-584-3114 Fax

---

### Payment of Check Info

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

(Personal or business name on check)

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

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

( To Mail Check)

**SSN# or EIN#** \_\_\_\_\_

(SSN-need copy of SS Card/ EIN# need letter W/EIN#)

**ONE CALL, PROBLEM SOLVED!**





## Credit Authorization

### AUTHORIZATION FORM FOR DIRECT DEPOSIT ACH CREDITS

I hereby authorize 2S Transport LLC, hereinafter called COMPANY, to initiate credit entries for \_\_\_\_\_ to my account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Financial Institution Name:	Branch:
Address:	Type of Account (check one below):
City/State:	Checking:
ZIP:	Savings:

Account Name:
Routing Number:
Acct Number:

This authority is to remain in full force and effect until 2S Transport LLC has received written notification from \_\_\_\_\_ of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

Print Individual Name:
Individual ID Number:
Signature:
Date:

**PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM!**

## Request for Taxpayer Identification Number and Certification

**Give Form to the  
requester. Do not  
send to the IRS.**

Print or type See Specific instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate  <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____  <input type="checkbox"/> Other (see instructions) ▶ _____	
	Exemptions (see Instructions):  Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number		
	-	
	-	

Employer identification number		
	-	
	-	

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

**Sign Here**

Signature of U.S. person ▶

Date ▶

### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** The IRS has created a page on [www.irs.gov/w9](http://www.irs.gov/w9) for information about Form W-9, at [www.irs.gov/w9](http://www.irs.gov/w9). Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

#### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the

withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

**Note.** If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744

If you are not certain whether all parties meet the requirements for entering into this agreement, you may wish to consult an attorney.

CHECK  BOX OF STATEMENT THAT APPLIES

AGREEMENT BETWEEN MOTOR CARRIER AND OWNER OPERATOR TO PROVIDE WORKERS' COMPENSATION INSURANCE COVERAGE

Notice of Declaration

The undersigned Motor Carrier and the undersigned Owner Operator agree that the Motor Carrier will provide workers' compensation insurance coverage to the Owner Operator and the Owner Operator's employees. The Motor Carrier  will deduct  will not deduct the actual premiums, based on payroll, that are paid or incurred by the Motor Carrier for coverage from the contract price or any other amount owed to the Owner Operator by the Motor Carrier.

TERM (DATES) OF AGREEMENT: FROM: \_\_\_\_\_  
TO: \_\_\_\_\_

ESTIMATED NUMBER OF WORKERS AFFECTED: \_\_\_\_\_  
Texas Labor Code, Texas Workers' Compensation Act, Section 406.123.

AGREEMENT TO REQUIRE OWNER OPERATOR TO ACT AS EMPLOYER

Notice of Agreement

The undersigned Motor Carrier and the undersigned Owner Operator agree that the Owner Operator assumes the responsibilities of an employer for the performance of work.

TERM (DATES) OF AGREEMENT: FROM: \_\_\_\_\_  
TO: \_\_\_\_\_

ESTIMATED NUMBER OF WORKERS AFFECTED: \_\_\_\_\_  
Texas Labor Code, Texas Workers' Compensation Act, Section 406.122.

**THIS AGREEMENT SHALL TAKE EFFECT NO SOONER THAN THE DATE IT IS SIGNED.**

**MOTOR CARRIER'S AFFIRMATION**

If the Motor Carrier's workers' compensation carrier changes during the effective period of coverage, it is advisable for the Motor Carrier to file this form with the new insurance carrier.

\_\_\_\_\_  
Federal Tax I.D. Number

\_\_\_\_\_  
Signature of Motor Carrier

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address (Street)

\_\_\_\_\_  
Printed Name of Motor Carrier

\_\_\_\_\_  
Address (City, State, Zip)

**OWNER OPERATOR'S AFFIRMATION**

\_\_\_\_\_  
Federal Tax I.D. Number

\_\_\_\_\_  
Signature of Motor Owner Operator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address (Street)

\_\_\_\_\_  
Printed Name of Owner Operator

\_\_\_\_\_  
Address (City, State, Zip)

The Motor Carrier should retain the original. Legible copies of this agreement must be filed with the Motor Carrier's workers' compensation insurance carrier and the Division within 10 days of the date of execution. An agreement is not considered filed if it is illegible or incomplete. Filing may be accomplished by mail or facsimile transmission. The Owner Operator must also retain a copy of the agreement.

Division Date Stamp Here

