

# Independent Contractor

**Contractor Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In compliance with Federal and State equal employment opportunity laws, qualified candidates 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.

## To be Read and Signed by Independent Contractor

I authorize you to make such investigations and inquiries of my personal, employment, financial 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, carriers, schools, health care providers and other persons from all liability in responding to inquiries and releasing information in connection with my application.

I understand that false or misleading information given in my application or interview(s) may result in discharge. I also understand that I am required to abide by all rules and regulations of the Company.

I understand that information I provide regarding current and/or previous employers or carriers may be used, and those carriers / employer(s) will be contacted, for the purpose of investigating my safety performance history as required by 49 CFR 391.23(d) and (3). I understand I have the right to:

- Review information provided by previous carriers and/or employers;
- Have errors in the information corrected by previous carriers and/or employers and for those previous carriers / employers to re-send the corrected information to the prospective carrier; and
- Have a rebuttal statement attached to the alleged erroneous information, if the previous carrier(s) or employer(s) and I cannot agree on the accuracy of the information.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Independent Contractor Form

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

Federal ID #: \_\_\_\_\_

Corporation  DBA  Partnership  Sole Proprietor

Social Security #: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_

Cell Telephone #: \_\_\_\_\_

List your addresses of residence for the past 3-years; list current address first:

Street City State & Zip Code How long?

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

Have you been convicted of a felony within the last 7-years?  Yes  No

*If yes, please explain fully on a separate sheet of paper. Conviction of a crime is not an automatic bar to employment—all circumstances will be considered.*

Date of Birth: \_\_\_\_\_ Can you provide proof of age:  Yes  No  
Required for Commercial Drivers

Have you worked for this Company before?  Yes  No Dates: \_\_\_\_\_

Reason for leaving? \_\_\_\_\_

Are you Currently Employed?  Yes  No  
If not, how long since leaving your last employment? \_\_\_\_\_

Who referred you? \_\_\_\_\_

Is there any reason you might be unable to perform the functions of a commercial driver (tractor trailer)?  Yes  No  
If yes, explain if you wish: \_\_\_\_\_

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

## Previous Motor Carrier History

All Independent Contractors, in order to drive interstate commerce, must provide the following information on all carriers during the preceding 3-years. List complete mailing address including street number, city, state and zip code. To drive a commercial motor vehicle in intrastate or interstate commerce, Independent Contractors must also provide an additional 7-years information on those carriers for whom the Contractor operated such a vehicle.

**Note:** List carriers in reverse order starting with the most recent; add another sheet if necessary.

Carrier:	_____		
Address:	_____		
	_____		
Contract From:	_____	To: _____	Pay Rate: _____
Position Held:	_____		
Contact Person / Phone Number:	_____		
Reason for Leaving:	_____		
Were you subject to the FMCSR while employed in this position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was your job designated as a safety-sensitive function subject to the drug and alcohol testing requirements of 49 CFR Part 40?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Carrier:	_____		
Address:	_____		
	_____		
Contract From:	_____	To: _____	Pay Rate: _____
Position Held:	_____		
Contact Person / Phone Number:	_____		
Reason for Leaving:	_____		
Were you subject to the FMCSR while employed in this position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was your job designated as a safety-sensitive function subject to the drug and alcohol testing requirements of 49 CFR Part 40?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Carrier:	_____		
Address:	_____		
	_____		
Contract From:	_____	To: _____	Pay Rate: _____
Position Held:	_____		
Contact Person / Phone Number:	_____		
Reason for Leaving:	_____		
Were you subject to the FMCSR while employed in this position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was your job designated as a safety-sensitive function subject to the drug and alcohol testing requirements of 49 CFR Part 40?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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

Contract From: \_\_\_\_\_ To: \_\_\_\_\_ Pay Rate: \_\_\_\_\_  
 Position Held: \_\_\_\_\_  
 Contact Person / Phone Number: \_\_\_\_\_  
 Reason for Leaving: \_\_\_\_\_

Were you subject to the FMCSR while employed in this position?  Yes  No  
 Was your job designated as a safety-sensitive function subject to the drug and alcohol testing requirements of 49 CFR Part 40?  Yes  No

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

Contract From: \_\_\_\_\_ To: \_\_\_\_\_ Pay Rate: \_\_\_\_\_  
 Position Held: \_\_\_\_\_  
 Contact Person / Phone Number: \_\_\_\_\_  
 Reason for Leaving: \_\_\_\_\_

Were you subject to the FMCSR while employed in this position?  Yes  No  
 Was your job designated as a safety-sensitive function subject to the drug and alcohol testing requirements of 49 CFR Part 40?  Yes  No

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

Contract From: \_\_\_\_\_ To: \_\_\_\_\_ Pay Rate: \_\_\_\_\_  
 Position Held: \_\_\_\_\_  
 Contact Person / Phone Number: \_\_\_\_\_  
 Reason for Leaving: \_\_\_\_\_

Were you subject to the FMCSR while employed in this position?  Yes  No  
 Was your job designated as a safety-sensitive function subject to the drug and alcohol testing requirements of 49 CFR Part 40?  Yes  No

**Accident Record** for Past 3-Years or More (attach additional sheet if more space is needed). If none, please write NONE.

Date	Nature of Accident	Fatalities?	Injuries?
Last Accident: _____			
Next Previous: _____			
Next Previous: _____			

**Traffic Convictions** and Forfeitures for the past 3-years (other than parking violations): If none, please write NONE.

Location	Date	Charge	Penalty
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Experience** and Qualifications: List all driver licenses or permits held in the past 3-years.

State	License #	Type	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been denied a license, permit or privilege to operate a motor vehicle?  Yes  No

Has any license, permit or privilege ever been suspended or revoked?  Yes  No

*If the answer to either question above is YES, please give details.*

\_\_\_\_\_

\_\_\_\_\_

Class of Equipment:  Tractor & Semi-Trailer  Tractor & 2 Trailers  
 Van  Reefer  Flat Bed  Tank  Other \_\_\_\_\_

List states operated in for last five (5) years: \_\_\_\_\_

\_\_\_\_\_

List special courses or training that will help you as a driver: \_\_\_\_\_

\_\_\_\_\_

**Education -- Circle Highest Grade Completed:**

1 2 3 4 5 6 7 8 9 10 11 12

School: \_\_\_\_\_  
School Name City / State

College: \_\_\_\_\_ 1 2 3 4  
School Name City / State

Other: \_\_\_\_\_ 1 2 3 4  
School Name City / State

Have you, in the two (2) years preceding the date of this application, tested positive, refused or failed to provide a urine sample for any motor carrier for whom you did not undertake safety sensitive functions?  Yes  No

**Commercial Drivers' License Information:**

State: \_\_\_\_\_ CDL # \_\_\_\_\_ Class: \_\_\_\_\_

Endorsements: \_\_\_\_\_

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

**Type of Equipment:**

Power Unit Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year \_\_\_\_\_

Serial #: \_\_\_\_\_

IRP:  Yes  No If yes, IRP Number: \_\_\_\_\_

TMT:  Yes  No IFTA:  Yes  No

**Insurance:**

Bobtail Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Workers Compensation:  Yes  No

If Yes, Company Name: \_\_\_\_\_ Policy # \_\_\_\_\_

**To be read and signed by Independent Contractor:**

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: \_\_\_\_\_

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

## AUTHORIZATION FORM FOR CONSUMER REPORTS

In connection with your application for employment (including contract for services), understand that consumer reports or investigative consumer reports which may contain public record information may be requested or made on you including consumer credit, criminal records, driving record, education, prior employer verification, workers compensation claims and others. These reports will include experience information along with reasons for termination of past employment. Further, understand that information from various Federal, State, local and other agencies which contain your past activities will be requested. A consumer report containing injury and illness records and medical information may be obtained only after a tentative offer of employment has been made.

By signing below, you hereby authorize without reservation, any party or agency contacted by this employer to furnish the above mentioned information. You further authorize ongoing procurement of the above mentioned reports at any time during your employment (or contract). You also agree that a fax or photocopy of this authorization with your signature be accepted with the same authority as the original.

You have the right to make a request of First Advantage, upon proper identification and the payment of any legally permissible fees, for the information in its files on you at the time of your request.

You hereby authorize and request, without any reservation, any present or former employer, school, police department, financial institution, division of motor vehicles, consumer reporting agencies, or other persons or agencies having knowledge about you to furnish First Advantage with any and all background information in their possession regarding you, in order that your employment qualifications may be evaluated.

For California, Minnesota or Oklahoma applicants only, if you would like to receive a copy of the consumer report, if one is obtained, please check this box.  If checked and you are a California applicant, a copy of the consumer report will be sent within three (3) days of the employer receiving a copy of the consumer report.

For California applicants only, if public record information about your character, general reputation, personal characteristics, and mode of living is obtained without using a consumer reporting agency, you will be supplied a copy of the public record information within seven (7) days of the employer's receipt unless you check this box where you hereby waive your right to obtain a copy of the consumer report.

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

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

**City: State: Zip:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Drivers License State: License Number:** \_\_\_\_\_

*The following is for identification purposes only to perform the background check:*

**Date of Birth (MM/DD/YYYY):** \_\_\_\_\_ **Race:** \_\_\_\_\_ **Gender (M or F):** \_\_\_\_\_

**Other or Former Names:** \_\_\_\_\_

**Professional License:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Type:** \_\_\_\_\_ **Number:** \_\_\_\_\_

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

# Pre-Employment Urinalysis Notification

The Federal Motor Carrier Safety Regulations, Section 382.031 pre-employment testing requirements, apply to driver-applicants of this company.

## §382.301 Pre-employment Testing Requirements

- a) A motor carrier shall require a driver-applicant who the motor carrier intends to hire or use to be tested for the use of controlled substances as a pre-qualification condition.
- b) A driver-applicant shall submit to controlled substance testing as a pre-qualification condition.
- c) Prior to collection of urine sample under §382.301 of this sub-part, a driver-applicant shall be notified that the sample will be tested for the presence of controlled substances.

As a condition of my employment, I agree to the urine sample collection and controlled substance testing.

I understand a positive test for controlled substance based on the urinalysis test will medically disqualify me from the operation of a commercial motor vehicle for this company.

The Medical Review Officer will maintain the results of the Urinalysis Test. Negative and positive tests will be reported to the company.

My written authorization is required for the Urinalysis Test results to be given to other parties.

I have read and understand the above conditions for the Pre-Employment Urinalysis notification.

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

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

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

Witnessed by: \_\_\_\_\_  
Company Representative

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

**The Shaker Group, Inc**

862 Albany Shaker Road / Latham, NY 12110  
Telephone #518-786-9286 Fax #518-782-7226

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

Driver Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Position Applied For at The Shaker Group, Inc.: CDL-A / Tractor Trailer Driver

Prior Position with Your Company: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ to \_\_\_\_\_

Reason for Leaving:  Resigned  Discharged  Laid-Off

Did S/He Drive a Motor Vehicle For You?  Yes  No  
 Tractor Trailer  Straight Truck  Tanker  Van  Doubles  
 OTR  Regional  Local  Yard  
Length of Trailer:  48-foot  53-foot  Other

**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	# of Injuries	# of Fatalities	Details

**Drug & Alcohol History:** If driver was not subject to Department of Transportation testing requirements while employed with you, please check here . If driver was subject to DOT testing requirements, please complete the following:

Has this person had an alcohol test with a result of 0.04 or higher alcohol concentration?  Yes  No  
Has this person had a verified positive drug test?  Yes  No  
Has this person refused to be tested (including verified adulterated or substituted drug test results)?  Yes  No  
Has this person committed other violations of DOT agency drug and alcohol testing regulations?  Yes  No  
If this person has violated a DOT drug and alcohol regulation, do you have documentation of the employee's successful completion of DOT return-to-work duty requirements, including follow-up tests? (Please send this documentation back with this form, if applicable.)  Yes  No

In answering these questions, include any drug or alcohol testing information obtained from previous employers under 40.25 or other applicable DOT agency regulations.

Name: \_\_\_\_\_  
Company: \_\_\_\_\_  
Street / City / State: \_\_\_\_\_

Preparer's Signature: \_\_\_\_\_ Print Last Name: \_\_\_\_\_

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

I hereby authorize you to release the requested information to **The Shaker Group, Inc.**, for the purpose of investigation as required by §391.23 and allowed by §383.35 of the Federal Motor Carrier Safety Regulations. You are released from any and all liability which may result from furnishing such information.

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

## Certification of Compliance With CDL Requirements

**Motor Carrier Instructions:** The requirements in Part 383 apply to every Independent Contractor 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 operator 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.

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

1. You, as a commercial vehicle operator, may not possess more than one license. The only exception is if a state requires you to have more than one license. This exception is allowed until January 1, 1990.

If you currently have more than one license, you should 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, you should close your record by notifying the state of issuance that you no longer want to be licensed by that state.

2. Sections 392.42 and 383.33 of the Federal Motor Carrier Safety Regulations require that you notify the carrier the **next business day** of any revocation or suspension of your commercial license. In addition, §383.31 requires that any time you violate a state or local traffic law (other than parking), you must report it to the motor carrier and the state that issued your license within 30-days.

**Independent Contractor Certification:** I certify that I have read and understood the above requirements. The following license is the only one I will possess:

CDL Number: \_\_\_\_\_ State: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Independent Contractor Signature:

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

## DRIVER STATEMENT OF ON-DUTY HOURS

**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 for 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 \_\_\_\_\_  
 Endorsement(s) \_\_\_\_\_ Restriction(s) \_\_\_\_\_

Type of License \_\_\_\_\_ Issuing State \_\_\_\_\_

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

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

\_\_\_\_\_ (AM / PM) On \_\_\_\_\_  
 Time Day Month Year

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

### DRIVER CERTIFICATION FOR OTHER COMPENSATED WORK

**INSTRUCTIONS:** When employed by a motor carrier, a driver must report to the carrier all on-duty time including time working for other employers or carriers. The definition of on-duty time found in Section 395.2 paragraphs (8) and (9) of the Federal Motor Carrier Safety Regulations includes time performing any other work in the capacity of, or in the employ or service of, a common, contract or private motor carrier, also performing any compensated work for any non-motor carrier entity.

Are you currently working for another employer / carrier: (check one)  
 Yes No

At this time do you intend to work for another carrier while contracting with this company? Yes No

I hereby certify that the information given above is true and I understand that once I become an Independent Contractor with this company, if I begin working for any additional employer or carrier for compensation that I must inform this company immediately of such activity.

\_\_\_\_\_  
 Drivers Signature Date

Witness: \_\_\_\_\_  
 Company Representative Date