

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:	Rachael Luvata	Social Security Number:	260 28 6892
Date of Application:	5 May 2017	Driver's License Number:	B66181331
License Expiration Date:	8 2020	Date of Birth:	8 May 75
Address 1:	3704 Jackson Lane Bnd	Address 2:	
City:	Hopewell	State:	VA
Zip:	23960	Telephone:	571 315 9197

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.

Applicant Authorization (Signature)

SIGN HERE

Date

Employer and/or Third Party		INTERCEPT CORPORATION
Name:	Ray Salmon Trucking	1700 42nd St. S, Suite 2000
Street Address:	9137 Justice Rd	Fargo, ND 58103
City, State, Zip:	Langrune, ND 58138	
Telephone:	443-629-4648	
Fax Number:	443-299-6004	

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

I hereby authorize on this 5 day of May, 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 EFT 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 EFT 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.

Electronic Funds Transfer (15 U.S.C. § 1693): I hereby acknowledge receipt of notice by the financial institution described here within of: (i) the undersigned's liability for an unauthorized electronic fund transfer, (ii) the undersigned's duty to promptly report such unauthorized transfers, (iii) the undersigned's liability for charges for electronic fund transfers, (iv) the undersigned's right to stop payment of pre-authorized electronic fund transfers, (v) the procedure to initiate such stop payment orders, (vi) the right to receive documentation of electronic fund transfers, and (vii) the Bank's liability pursuant to the Electronic Funds Transfer Act found at 15 U.S.C. § 1693, et al.

Limitation of Action: I acknowledge that I have 60 days from the date of a withdrawal from or deposit to the account shown below to dispute the withdrawal or deposit by contacting my employer and Intercept Corporation by telephone and later supplemented in writing, or in writing of any discrepancies, errors or disputes concerning any transfer of funds to or from any account processed by Intercept. This will include but not limited to, errors in amounts, erroneous transactions, or other transactions processed. All written notices must include the following information:

- a) The name of the company with whom the undersigned authorized the transaction, i.e., employer and/or third party;
- b) Federal Taxpayer ID number of the company authorized to make the transaction;
- c) Federal Taxpayer ID number of the undersigned;
- d) The name of the undersigned;
- e) The name, account number and ABA number on the transaction in question;
- f) The dollar amount of the transaction in question; and
- g) Description of the error and explanation of the error.

I understand and agree that my employer, its agent, or IC will inform me of the results of their investigation within ten (10) days of the receipt of the complaint and will correct any error promptly. I understand and agree that if my employer, and/or its agent, or IC need more time, IC may take up to 45 days to investigate the undersigned's complaint. For transfers initiated outside the United States or transfers resulting from point of sale or debit/access cards, the time periods for resolving errors will be 45 days and 90 days respectively.

Rodney Livalt
Undersigned's Name
USAA
Financial Institution
City

5 May 2017
Date
Branch
800 582 5200
Phone Number

314074269
Routing (ABA) Number

100230574 Account Number Account Type: Checking ☐ Savings ☐

Routing (ABA) Number

 Account Number Account Type: Checking ☐ Savings ☐

Boys
Undersigned's Signature

260 256392
Social Security Number

Please attach to this authorization a voided personal check for verification of all checking account information.

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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank. <i>Regney Luant</i>	
2 Business name/disregarded entity name, if different from above	
3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input checked="" type="checkbox"/> Other (see instructions) ▶	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <small>(Applies to accounts maintained outside the U.S.)</small>
5 Address (number, street, and apt. or suite no.) <i>3704 Jackson Farm Rd</i>	Requester's name and address (optional)
6 City, state, and ZIP code <i>Hopewell VA 23560</i>	
7 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 line 1 to avoid backup withholding. For individuals, this is generally 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 instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number										
2	6	0	-	2	5	-	6	3	9	2
or										
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 ▶ *5 May 2017*

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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. See *What is FATCA reporting?* on page 2 for further information.

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 1 minute per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRR, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examiner's Certificate
(for Commercial Driver Medical Certification)

I certify that I have examined Last Name: LIVATT First Name: Rodney in accordance with (please check only one):

☒ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) OR

☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply):

☐ Wearing corrective lenses ☐ Accompanied by a _____ waiver/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)

☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)

☐ Grandfathered from State requirements (State)

Medical Examiner's Certificate Expiration Date
11/15/2018

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature <u>[Signature]</u>	Medical Examiner's Telephone Number <u>703-497-1234</u>	Date Certificate Signed <u>11/15/16</u>
Medical Examiner's Name (please print or type) <u>Laura Rigney</u>	<input type="radio"/> MD <input type="radio"/> Physician Assistant <input checked="" type="radio"/> Advanced Practice Nurse	<input type="radio"/> DO <input type="radio"/> Chiropractor <input type="radio"/> Other Practitioner (specify) _____
Medical Examiner's State License, Certificate, or Registration Number <u>0024164011</u>	Issuing State <u>VA</u>	National Registry Number <u>9347575083</u>

Driver's Signature <u>[Signature]</u>	Driver's License Number <u>B66171331</u>	Issuing State/Province <u>VA</u>
Driver's Address <u>3704 Jackson Farm Rd</u>	City <u>Hopewell</u>	State/Province <u>VA</u>
Street Address	Zip Code <u>23560</u>	CLP/CDL Applicant/Holder <input checked="" type="radio"/> Yes <input type="radio"/> No

Virginia

VA, USA

COMMERCIAL DRIVER'S LICENSE

Customer identifier

B66171331

Name

LIVATT

RODNEY, MERSHION

Address

3704 JACKSON FARM RD
HOPEWELL, VA 23860-4009

Sex

M

Class

A

Date of birth

07/08/1975

Eyes

BRO

Endorsements

NONE

Iss REI

12/29/2016

Height

5 FT 6 IN

Restrictions

NONE

Exp

07/08/2020

DD 077284748



www.dmvNow.com



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U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

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(for Commercial Driver Medical Certification)

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☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply):

☐ Wearing corrective lenses ☐ Accompanied by a _____ waiver/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)

☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)

☐ Grandfathered from State requirements (State)

Medical Examiner's Certificate Expiration Date
11/15/2018

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature <u>[Signature]</u>	Medical Examiner's Telephone Number <u>703-497-1234</u>	Date Certificate Signed <u>11/15/16</u>
Medical Examiner's Name (please print or type) <u>Laura Rigney</u>	<input type="radio"/> MD <input type="radio"/> Physician Assistant <input checked="" type="radio"/> Advanced Practice Nurse <input type="radio"/> DO <input type="radio"/> Chiropractor <input type="radio"/> Other Practitioner (specify) _____	
Medical Examiner's State License, Certificate, or Registration Number <u>0024164011</u>	Issuing State <u>VA</u>	National Registry Number <u>9347575083</u>

Driver's Signature <u>[Signature]</u>	Driver's License Number <u>B66171331</u>	Issuing State/Province <u>VA</u>
Driver's Address Street Address: <u>3704 Jackson Farm Rd</u> City: <u>Hopewell</u> State/Province: <u>VA</u> Zip Code: <u>23560</u>	CLP/CDL Applicant/Holder <input checked="" type="radio"/> Yes <input type="radio"/> No	

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: <i>Rachey Livatt</i>	Date of Application: <i>5 May 17</i>
Current Address: <i>1932 Winslow Ct</i> <i>Woodbridge VA 22191</i>	Social Security No.: <i>260 25 6392</i>
Length of time at this address:	Date of Birth: <i>8 Jul 75</i>
	Telephone No.: <i>571 315 9797</i>

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 <input type="checkbox"/>
<i>VA</i>	<i>B66171331</i>	<i>7/18/20</i>	

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 <input type="checkbox"/>
<i>Tractor / Trailer</i>	<i>18</i>	
<i>Bus</i>	<i>10</i>	

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

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

DQF 1 - APPLICATION FOR EMPLOYMENTRetain 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>US Army</u>	Employed From: <u>4/11/96</u>	To: <u>1/2017</u>
Address:	Position: <u>Driver instructor</u>	
	Salary:	
Contact: Phone: <u>703 696 6469</u>	Reason for Leaving: <u>retired</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 type="checkbox"/> Yes <input type="checkbox"/> No		

Employer Name:	Employed From: /	To: /
Address:	Position:	
	Salary:	
Contact: Phone:	Reason for Leaving:	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Employer Name:	Employed From: /	To: /
Address:	Position:	
	Salary:	
Contact: Phone:	Reason for Leaving:	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input 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: 5 May 2017

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 _____ 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).

Bodney Livatt
Driver's Full Name

[Signature]
Driver's Signature

SIGN HERE

5 May 2017
Date

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: Anthony Livata Social Security Number: 240 256 3012 Client Code: _____

Applicant's Signature: [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)

____/____/____ 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

____ 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



10124584

4946280

SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

LAB ACCESSION NO.

A. Employer Name, Address, I.D. No.
 RBY SALMON TRUCKING
RBY 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 MRO SERVICES
140 HUYSHOPE AVE
HARTFORD CT 06106
PH: 860-815-0825 FAX: 860-920-5260
C. Donor SSN or Employee I.D. No.
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)

() 45304M DDT DRUG PANEL W/T/S

G. Collection Site Name:

Collection Site Code:

 Address: 1419 K Street Ave
City, State and Zip: Baltimore MD 21207 MD048

Collector Phone No.: 410-247-9515

Collector Fax No.: 410-247-7553

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.

X

Signature of Collector

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

Date (Mo./Day/Yr.)

Time of Collection

SPECIMEN BOTTLE(S) RELEASED TO:☐ Quest Diagnostics Courier☐ FedEx☐ Other

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

Rodney Livatt

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

5/4/17

Date (Mo./Day/Yr.)

Daytime Phone No. 570 315 9797

Evening Phone No. ()

Date of Birth 7/8/75

Mo. Day Yr.

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.)

Virginia

VA, USA

COMMERCIAL DRIVER'S LICENSE

Customer identifier

B66171331

Name

LIVATT

RODNEY, MERSHION

Address

3704 JACKSON FARM RD
HOPEWELL, VA 23860-4009

Sex

M

Class

A

Date of birth

07/08/1975

Eyes

BRO

Endorsements

NONE

Iss REI

12/29/2016

Height

5 FT 6 IN

Restrictions

NONE

Exp

07/08/2020

DD 077284748



B66171331

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