

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>Kenneth S. Carey</i>	Date of Application: <i>7-17-17</i>
Current Address: <i>5563 OAKLAND RD. Halethorpe, Md 21227</i>	Social Security No.: <i>216-96-9865</i>
Length of time at this address: <i>4 yrs.</i>	Date of Birth: <i>02-25-1966</i>
	Telephone No.: <i>443-202-0370</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
<i>Maryland</i>	<i>C-100-465-777-146</i>	<i>02-25-2018</i>	<input type="checkbox"/>

LIST THE NATURE AND EXTENT OF YOUR EXPERIENCE OPERATING DIFFERENT TYPES OF MOTOR VEHICLES (E.G. BUSES, TRUCKS & TRAILERS)		
Type	Experience in Years and / or Miles Driven	Additional Information Attached
<i>CLASS A (VANS, REEFERS, LOWBOYS)</i>	<i>20+ yrs.</i>	<input type="checkbox"/>

LIST ALL MOTOR VEHICLE ACCIDENTS IN WHICH YOU WERE INVOLVED DURING THE LAST THREE YEARS				
DATE	CITY/STATE	NATURE OF ACCIDENT	FATALITIES	INJURIES
		<i>NONE</i>		

☒ 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
<i>4/17</i>	<i>Greenbelt, Md</i>	<i>DRIVING ON RESTRICTED ROAD</i>	<i>FINE \$105.00</i>
<i>5/17</i>	<i>LAUREL, MD</i>	<i>NO SEATBELT</i>	<i>FINE 170.00</i>

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

CDL

Endors:

Class Commercial
A Driver's License

Maryland

LIC #: C-100-465-777-146

KENNETH STEINMAX CAVEY

5563 OAKLAND RD

HALETHORPE BA MD 21227



BIRTH DATE: 02-25-1966

EXPIRES: 02-25-2018

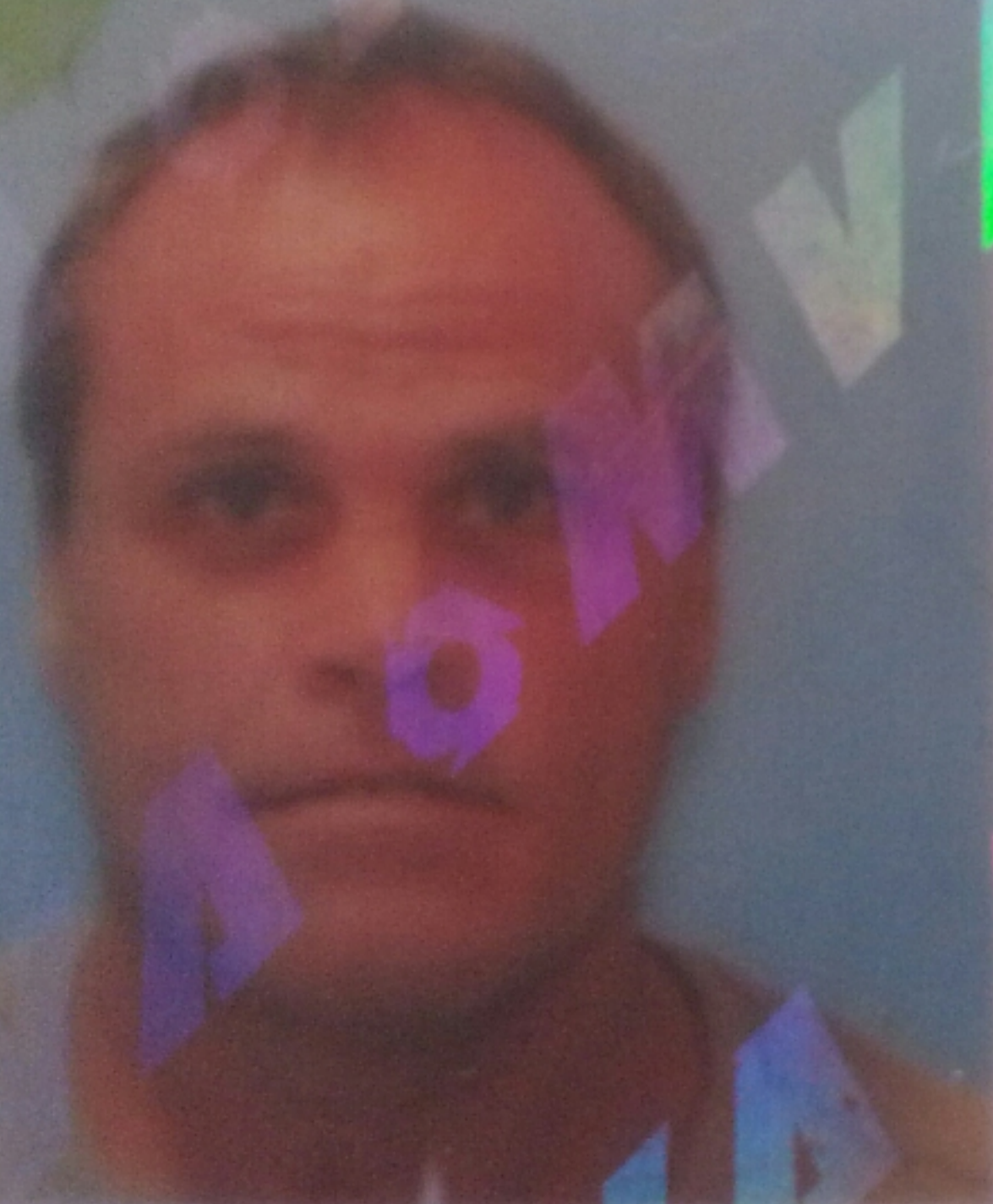
Sex: M HT: 5-10 WT: 209

Restr: Type: C

Issue Date: 06-22-2016

02-25-1966

1201900AB



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>MARYLAND PAVING</u>	Employed From: <u>1117</u> To: <u>7117</u>
Address: <u>11035 Guilford Rd Jessup, Md</u>	Position: <u>CLASS A driver</u>
Contact: <u>STEVE STANLEY</u> Phone: <u>301-300-5299</u>	Salary: <u>20.00 / Hr.</u>
Reason for Leaving: <u>Tired of running long miles</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name: <u>Coldline Express</u>	Employed From: <u>10116</u> To: <u>1117</u>
Address: <u>17 Volcan Way Columbus OH</u>	Position: <u>OTR Reefer driver</u>
Contact: <u>MARLI Hunter</u> Phone: <u>614-368-4182</u>	Salary: <u>.40 / mile</u>
Reason for Leaving: <u>TO MUCH TIME ON ROAD</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

Employer Name:	Employed From: <u>12114</u> To: <u>10117</u>
Address: <u>11035 Guilford Rd Maryland Paving Jessup, Md</u>	Position: <u>CLASS A driver</u>
Contact: <u>STEVE STANLEY</u> Phone: <u>3013005299</u>	Salary: <u>20.00 / Hr.</u>
Reason for Leaving: <u>slow work periods</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

OFFICE USE ONLY

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

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

Applicant Signature: Bernette L. Cy

SIGN HERE

Date: 7-17-17

Foley

© 2015 Foley Carrier Services, LLC. All Rights Reserved.
140 Huyshope Avenue • Hartford, CT 06106

To Reorder, Call 800.253.5506
or Visit www.foleyservices.com

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
Employer Name
 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).

Kenneth S. Carey
 Driver's Full Name

Kenneth S. Carey
 Driver's Signature

SIGN HERE

7-17-17
 Date

 Supervisor/Authorized Motor Carrier Representative Signature

SIGN HERE

 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: Kenneth S. Carey Social Security Number: 216-96-9865 Client Code: _____

Applicant's Signature: Kenneth S. Carey 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

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: Bennett, P. Cary Social Security Number: 216-96-985 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

Foley

© 2015 Foley Carrier Services, LLC. All Rights Reserved.
140 Huyshope Avenue • Hartford, CT 06106

To Reorder, Call 800.253.5506
or Visit www.foleyservices.com.

SPH 2/3/R - SAFETY PERFORMANCE HISTORY INVESTIGATION

Retain for 3 years after the driver leaves your employment

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: Bennett S. Cacy Social Security Number: 216 96 9865 Client Code: _____

Applicant's Signature: Bennett S. Cacy 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

Page 2 Employment History

Payne Trucking 3/14 TO 12/14
111 Hall Industrial Dr. CONTACT: Gloria Phone 540-898-
Fredericksburg, VA. 1346

Maryland Paving 6/11 TO 3/14
11036 Guilford Rd CONTACT: STEVE STANLEY Phone 301-300-
5299

Wongco Trucking
3355 Odonnell St. 3/07 TO 6/11 Phone: 410-256-0721
Balt., MD CONTACT: LANCE WONG

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 Project, Paperwork Project, Federal Motor Carrier Safety Administration, NRC-88A, 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: CAVEY First Name: Kenneth 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)

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 Certificate Expiration Date

6/10/18

Medical Examiner's Signature

Christopher O. Lockhart

Medical Examiner's Name (please print or type)

Christopher O. Lockhart, PA-C

Medical Examiner's State License, Certificate, or Registration Number

C01517

Medical Examiner's Telephone Number

410.247.9595

Date Certificate Signed

6/10/16

- ☐ MD ☒ Physician Assistant ☐ Advanced Practice Nurse
- ☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) _____

Issuing State

MD

National Registry Number

1851569362

Driver's Signature

Kenneth S. Cavey

Driver's Address

Street Address: 5563 Oakland Rd

City: Halethorpe

Driver's License Number

C-100-465-777-146

Issuing State/Province

MARYLAND

CLP/CDL Applicant/Holder

Zip Code: 21227 Yes ☒ No ☐



Vehicle Safety Policy

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

ROY SALMON TRUCKING LLC will:

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

THE DRIVER will:

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

DISTRACTED DRIVING /CELLULAR PHONE USE

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

free and/or texting laws. If you are cited violating any of these states laws, you will be responsible for the fines incurred.

EMPLOYEE ACKNOWLEDGMENT FORM

Because you are a valued member of our team, ROY SALMON TRUCKING LLC provides you with a company-owned vehicle. This vehicle should be used for business reasons, and you should never allow anyone else to drive the vehicle.

Since we are entrusting you with our vehicle, we ask that you treat it with the same care you would give your own.

I AGREE TO THE FOLLOWING:

- 1) I agree to be held accountable for the repair of any damages that are beyond normal wear and tear.
- 2) I agree to schedule the vehicle for the prescribed regular maintenance services.
- 3) I agree to drive safely, carefully, with common sense, and to obey the rules of the road.
- 4) I agree to not let any other person drive my vehicle at any time.
- 5) I have read and understand the Vehicle Safety Policy.

Print Name Kenneth S. Caley

Signature Kenneth S. Caley

Date 7.20.17

Employer and/or Third Party		INTERCEPT CORPORATION
Name:		1700 42nd St. S, Suite 2000
Street Address:		Fargo, ND 58103
City, State, Zip:		
Telephone:		
Fax Number:		

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

I hereby authorize on this 21 day of July, 2017 my employer and/or third party as referred to here within, and their agents including Intercept Corporation (IC), to initiate electronic withdrawals and/or deposits to the bank account shown below. I understand that adjustment and/or reversing entries may be made to this account to insure an accurate and balanced accounting of all transactions. This authorization will remain in effect until;

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

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

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



10124584

4946283

10124584

4946283

SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

LAB ACCESSION NO.

A. Employer Name, Address, I.D. No.

 ROY SALMON TRUCKING
 ROY SALMON
 9737 EUSTICE ROAD
 RANDALLSTOWN MD 21133
 PH: 443-629-4648 FAX:
B. MRO Name, Address, Phone No. and Fax No. **MDA500020**
 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. **216 96 9865**D. Specify Testing Authority: ☐ HHS ☐ NRC ☒ DOT - Specify DOT Agency: ☒ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCGE. 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)☒ 45304N DOT DRUG PANEL W/TS

Concentra Medical Centers

1419 Knecht Avenue

Baltimore, MD 21227

G. Collection Site Name:

Collection Site Code:

Address: **410-247-9595****MD048**

Collector Phone No.:

City, State and Zip: **410-247-7553**

Collector Fax No.:

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark: Collection: ☒ Split ☐ Single ☐ None Provided, Enter Remark: ☐ Observed, (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

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

SPECIMEN BOTTLE(S) RELEASED TO:

X☒ Quest Diagnostics Courier☐ FedEx☐ Other

Signature of Collector

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

Date (Mo./Day/Yr.)

Time of Collection

Name of Delivery Service

STEP 5: COMPLETED BY DONOR

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

X

Signature of Donor

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

Date (Mo./Day/Yr.)

Daytime Phone No.

Evening Phone No.

Date of Birth

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:☐ TEST CANCELLED☐ FAILED TO RECONFIRM for:

REMARKS:

X

Signature of Medical Review Officer

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

Date (Mo./Day/Yr.)

10124584

4946283

SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

LAB ACCESSION NO.

A. Employer Name, Address, I.D. No.

 ROY SALMON TRUCKING
ROY SALMON
9737 EUSTICE ROAD
RANDALLSTOWN MD 21139
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
WARTFORD CT 06106
PH: 860-815-0825 FAX: 860-920-5260

C. Donor SSN or Employee I.D. No.

216 96 9865

D. Specify Testing Authority: ☐ HHS ☐ NRC ☒ DOT - Specify DOT Agency: ☒ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCGE. 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) _____
 Concentra Medical Centers
1419 Knecht Avenue
Baltimore, MD 21227
410-247-9595
410-247-7553

G. Collection Site Name:

Collection Site Code:

 Address: 410-247-9595
City, State and Zip: 410-247-7553

MD048

Collector Phone No.:

Collector Fax No.:

STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.

Temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark: Collection: ☒ Split ☐ Single ☐ None Provided, Enter Remark: ☐ Observed, (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

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

SPECIMEN BOTTLE(S) RELEASED TO:

X

☒ Quest Diagnostics Courier☐ FedEx☐ Other

Signature of Collector

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

Date (Mo./Day/Yr.)

Time of Collection

Name of Delivery Service

STEP 5: COMPLETED BY DONOR

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

X

Signature of Donor

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

Date (Mo./Day/Yr.)

Daytime Phone No.

Evening Phone No.

Date of Birth

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:☐ TEST CANCELLED☐ ADULTERATED (adulterant/reason): _____☐ SUBSTITUTED☐ OTHER _____

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

REMARKS: _____

X

Signature of Medical Review Officer

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

Date (Mo./Day/Yr.)