



The purpose of this application is to determine whether or not the applicant is qualified to operate Motor Carrier equipment according to the requirements of the Federal MCSR and American Logistics. Conditions of employment are stated at the end of this form. Please read carefully before you sign this application. (Application must be completed in full even if attaching a resume.)

American Logistics is an equal opportunity employer and will not discriminate against any applicant for employment because of race, color, religion, sex, national origin, sexual orientation, disability, age, marital status, or status with regard to public assistance. By completing this application, there is no assurance of employment. Use of this form does not indicate there are positions available.

Instructions: Please answer all questions. If the answer to any question is "no" or "none" do not leave the item blank, but write "No" or "None."

Date: _____

Name: _____
First Middle Last

Address: _____
Street City State Zip

If less than 1 year, list previous address: _____
Street City State Zip

Phone: _____
(Day) (Evening) (Cell Phone)

Are you authorized to work in the USA in the position for which you are applying? Yes No
Note: If hired, you will be required to show proof of employment authorization.

Have you previously **applied for work** or **worked for** American Logistics? Yes No

Are you at least 18 years of age? Yes No

PHYSICAL HISTORY

- 1. Do you have any impairment of:
 - A. Hand or fingers which interferes with prehension or grasping power? Yes No
 - B. An arm, foot, leg, or any limb defect/limitation which interferes with you ability to operate a motor vehicle Yes No
- 2. Do you have a medical history or clinical diagnosis of diabetes mellitus which requires insulin for control? Yes No
- 3. Do you have a current clinical diagnosis of any cardiovascular disease? Yes No
- 4. Do you have a medical history or current diagnosis of any of the following which might interfere with your ability to operate a motor vehicle safely:
 - Respiratory dysfunction Yes No
 - High blood pressure Yes No
 - Epilepsy Yes No
 - Rheumatism Yes No
 - Arthritis Yes No
 - Orthopedic, muscular, neuromuscular, or vascular disease Yes No
 - Mental, nervous, organic, or functional disease Yes No
 - Psychiatric disorder Yes No
 - Alcoholism Yes No
- 5. Do you use any Schedule I Drugs (opiates, opium derivatives, hallucinogenic substances, and stimulants), amphetamines, narcotics, or any other habit forming drug? Yes No
- 6. Do you have vision of 20/40 or better in each eye Yes No
- 7. Have you been granted a waiver under section 391.49 of the Federal Motor Carrier Safety Regulations pertaining to the loss of foot, leg, hand, or arm? Yes No



8. Last DOT Physical examination: _____ Doctor's Name/Address: _____
Date



GIVE A COMPLETE RECORD OF ALL EMPLOYMENT FOR THE PAST THREE YEARS INCLUDING ANY UNEMPLOYMENT OR SELF EMPLOYMENT & ALL COMMERCIAL DRIVING EXPERIENCE FOR THE PAST TEN YEARS

Mo./Yr. Mo./Yr. PRESENT OR LAST EMPLOYER:
 From ____ To ____ Name _____
 Phone (____) _____ Address _____
 Position Held _____ Salary _____
 Reasons for Leaving _____
 Subject to FMCSR's Yes No Safety Sensitive Function Yes No

Mo./Yr. Mo./Yr. NEXT PREVIOUS EMPLOYER:
 From ____ To ____ Name _____
 Phone (____) _____ Address _____
 Position Held _____ Salary _____
 Reasons for Leaving _____
 Subject to FMCSR's Yes No Safety Sensitive Function Yes No

Mo./Yr. Mo./Yr. NEXT PREVIOUS EMPLOYER:
 From ____ To ____ Name _____
 Phone (____) _____ Address _____
 Position Held _____ Salary _____
 Reasons for Leaving _____
 Subject to FMCSR's Yes No Safety Sensitive Function Yes No

Mo./Yr. Mo./Yr. NEXT PREVIOUS EMPLOYER:
 From ____ To ____ Name _____
 Phone (____) _____ Address _____
 Position Held _____ Salary _____
 Reasons for Leaving _____
 Subject to FMCSR's Yes No Safety Sensitive Function Yes No

Mo./Yr. Mo./Yr. NEXT PREVIOUS EMPLOYER:
 From ____ To ____ Name _____
 Phone (____) _____ Address _____
 Position Held _____ Salary _____
 Reasons for Leaving _____
 Subject to FMCSR's Yes No Safety Sensitive Function Yes No

PERSONAL REFERENCES

List three persons for reference, other than relatives, who have knowledge of your safety habits.

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____



Address: _____

Name: _____ Phone: _____

Address: _____

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	DATES		APPROXIMATE NO. OF MILES (TOTAL)
	FROM	TO	
Straight Truck			
Tractor and Semi-Trailer			
Tractor-Two Trailers			
Other			

List states operated in for the last five years: _____

Show special courses or training that will help you as a driver: _____

What Safe Driving Awards do you hold and from whom? _____

ACCIDENT RECORD FOR PAST 3 YEARS (attach sheet if more space is needed).

DATES	NATURE OF ACCIDENT (HEAD ON, REAR END, UPSET, ETC.)	# OF FATALITIES	# OF PEOPLE INJURED

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE LAST 3 YEARS (other than parking violations).

LOCATION	DATE	CHARGE	PENALTY

DRIVER'S LICENSE – List each driver's license held in the past 3 years

DRIVER'S LICENSES	STATE	LICENSE NO.	TYPE	EXPIRATION DATE



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- A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? Yes No
- B. Has any license, permit or privilege ever been suspended or revoked? Yes No
- C. Have you ever been a party to a law suit or any criminal prosecution other than debt collection proceedings or minor traffic citations? Yes No

If the answer to A, B, or C is YES, give details: _____



EDUCATION

Circle Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 College _____

Last School Attended _____
Name *City* *State*

EQUIPMENT OWNED – TRACTOR

Check one of the following: Individual Ownership Partnership Corporation

MAKE	YEAR	MODEL	SERIAL NUMBER	WHEELBASE	FUEL	TANK SIZE
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

EMPTY WEIGHT	TIRE SIZE	PLY	NO. AXLES	LICENSE NUMBER	STATE
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

HELD BY	TERMINATED	EQUIPMENT LIENS AMOUNT	PAYMENTS
_____	_____	_____	_____
_____	_____	_____	_____

INSURANCE COVERAGES			
INSURANCE CARRIER	AMOUNT	DEDUCTIBLE	
Collision: _____			
Bobtail: _____			
Other: _____			

PLEASE READ CAREFULLY AND EXAMINE YOUR APPLICATION BEFORE SIGNING TO SEE THAT YOU HAVE GIVEN AN ANSWER TO EACH AND EVERY ITEM.

I certify that the facts set forth in this employment application and/or my resume, if submitted, are true and complete to the best of my knowledge. I understand that any falsification, omission, misrepresentation or concealment of information on this application may be sufficient grounds for disqualification from further consideration for hire or immediate discharge and that American Logistics Services shall not be liable in any respect if my employment is so denied or terminated.

I authorize American Logistics Services to verify the information contained in this application and to investigate my personal or employment history. I also authorize any former school, employer, person, firm, corporation, credit agency or government agency to give American Logistics Services they may have about me. In consideration of American Logistics Services' review of this application, I release American Logistics Services and all providers of information from any liability as a result of furnishing and receiving this information.

I further agree that, if employed, I will conform my conduct to American Logistics Services rules and understand that unless otherwise specifically agreed to in writing, my employment can be terminated at any time with or without cause, and with or without notice, at my option or the option of American Logistics Services. I understand that no personnel recruiter, interviewer or other representative of American Logistics Services other than American Logistics Services President has authority to enter into any agreement for employment for any specified period of time. I also understand that this application and any employment manuals or handbooks that may be distributed to me during the course of my employment shall not be construed as a contract.



Signature of Applicant

Date