

The Arms Trucking Co.

Stanley Trucking Company, Inc. Scullion Trucking Co., Inc.
Arms Turf Products D.M. Boyd

Driver Application

P.O. Box 369
E. Clandon, Ohio 44033
800-362-1343

Date of Application: _____

DRIVER NAME _____		
(LAST)	(FIRST)	(MI)
ADDRESS _____		
CITY _____	STATE _____	ZIP _____
TELEPHONE NUMBER(____) _____ - _____		
DATE OF BIRTH _____		SOCIAL SECURITY # _____ - _____ - _____
IN CASE OF EMERGENCY - CONTACT _____		
NAME _____	PHONE # _____	RELATIONSHIP _____

PREVIOUS ADDRESSES FOR THE PAST THREE (3) YEARS

1. ADDRESS _____
CITY _____ STATE _____ ZIP _____ FROM _____ TO _____
2. ADDRESS _____
CITY _____ STATE _____ ZIP _____ FROM _____ TO _____
3. ADDRESS _____
CITY _____ STATE _____ ZIP _____ FROM _____ TO _____

COMMERCIAL DRIVER'S LICENSE INFORMATION

_____	TYPE _____	_____ / _____
LICENSE # _____	A,B OR C _____	STATE _____ EXP DATE _____
ENDORSEMENTS: (CIRCLE)	1. DOUBLE / TRIPLE TRAILERS	3. TANK VEHICLES
	2. PASSENGER VEHICLES	4. HAZARDOUS MATERIALS
LIST ANY ADDITIONAL LICENSE(S) HELD IN THE PAST 3 YEARS:		
STATE: _____	EXPIRATION DATE: _____	
STATE: _____	EXPIRATION DATE: _____	
HAS YOUR CDL EVER BEEN SUSPENDED OR REVOKED YES _____ NO _____		
IF YES, PLEASE EXPLAIN _____		

In compliance with federal and state equal opportunity laws, qualified applicants are considered for all positions without regard to race, religion, sex, national origin, age, marital status, or non-job related disability.

WORK EXPERIENCE

IN ACCORDANCE WITH PART 391.21 & 23 OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS, AN APPLICANT MUST LIST ALL PREVIOUS WORK EXPERIENCE FOR THE THREE YEARS PRIOR TO THE ABOVE APPLICATION DATE, AS WELL AS ALL COMMERCIAL DRIVING EXPERIENCE FOR SEVEN YEARS PRIOR TO THOSE THREE YEARS. PLEASE LIST STARTING WITH MOST RECENT.

COMPANY NAME: _____		
ADDRESS: _____	STATE: _____	ZIP CODE: _____
SUPERVISOR NAME : _____		PHONE _____
JOB DESCRIPTION: _____	WHY DID YOU LEAVE? _____	
FROM: ___ / ___ / ___	TO: ___ / ___ / ___	

COMPANY NAME: _____		
ADDRESS: _____	STATE: _____	ZIP CODE: _____
SUPERVISOR NAME : _____		PHONE _____
JOB DESCRIPTION: _____	WHY DID YOU LEAVE? _____	
FROM: ___ / ___ / ___	TO: ___ / ___ / ___	

COMPANY NAME: _____		
ADDRESS: _____	STATE: _____	ZIP CODE: _____
SUPERVISOR NAME : _____		PHONE _____
JOB DESCRIPTION: _____	WHY DID YOU LEAVE? _____	
FROM: ___ / ___ / ___	TO: ___ / ___ / ___	

COMPANY NAME: _____		
ADDRESS: _____	STATE: _____	ZIP CODE: _____
SUPERVISOR NAME : _____		PHONE _____
JOB DESCRIPTION: _____	WHY DID YOU LEAVE? _____	
FROM: ___ / ___ / ___	TO: ___ / ___ / ___	

COMPANY NAME: _____		
ADDRESS: _____	STATE: _____	ZIP CODE: _____
SUPERVISOR NAME : _____		PHONE _____
JOB DESCRIPTION: _____	WHY DID YOU LEAVE? _____	
FROM: ___ / ___ / ___	TO: ___ / ___ / ___	

COLLISIONS

PLEASE LIST MOTOR VEHICLE COLLISION IN WHICH YOU WERE INVOLVED (BOTH COMMERCIAL AND PRIVATE VEHICLE) DURING THE PAST THREE YEARS PRIOR TO THE APPLICATION DATE. IF NONE, WRITE " NONE"

DATE	DESCRIPTION	LOCATION	INJURIES/ FATALITIES
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____

TRAFFIC CONVICTIONS AND FORFEITURES

PLEASE LIST ALL TRAFFIC CONVICTIONS AND / OR FORFEITURES(BOTH COMMERCIAL AND PRIVATE) FOR THE PAST THREE YEARS (OTHER THAN PARKING). IF NONE, WRITE " NONE"

DATE	LOCATION	CHARGE	PENALTY
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____

DRIVING EXPERIENCE

EQUIPMENT CLASS	TYPE OF EQUIPMENT (VAN, DUMP, FLAT ETC.)	DATES		STATES DRIVEN
		FROM	TO	
STRAIGHT TRUCK	_____	_____	_____	_____
TRACTOR & SEMI TRAILER	_____	_____	_____	_____
TRACTOR & SEMI TRAILER	_____	_____	_____	_____
LIST COMMODITIES HAULED _____				

EDUCATION

PLEASE CIRCLE THE HIGHEST GRADE COMPLETED: 1 2 3 4 5 6 7 8 9 10 11 12 COLLEGE: 1 2 3 4

OTHER TRAINING _____

HAVE YOU RECEIVED ANY SAFETY AWARDS OR SPECIAL TRAINING? _____

DO YOU HAVE FULL KNOWLEDGE OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS? _____

GENERAL

HAVE YOU BEEN A DRIVER FOR THIS COMPANY BEFORE? YES _____ NO _____

IF SO, WHEN? _____ / _____ WHERE? _____

IS THERE ANY REASON YOU MIGHT BE UNABLE TO PERFORM THE THE FUNCTIONS OF THE JOB FOR WHICH YOU HAVE APPLIED ? YES _____ NO _____

IF YES PLEASE EXPLAIN? _____

HAVE YOU EVER BEEN CONVICTED FOR DUI, DWI OR OUI? YES _____ NO _____

MUST BE READ AND SIGNED BY THE APPLICANT

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

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

In event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I agree to abide by the rules and regulations of the carrier as well as the Federal Motor Carrier Safety Regulations. I also agree and understand that if I am selected to drive for the carrier that I will be on a probationary period during which time I may be discharge without recourse.

X _____ / / _____

Applicant Signature Date

ADDENDUM TO DRIVER APPLICATION

Pursuant to changes, effective August 1, 2001, in part 40 of the Federal Motor Carrier Safety Regulations, this addendum is added to the driver application and should be completed by each applicant. These changes require each motor carrier to inquire of prospective drivers the information in the question below.

Have you, the applicant, had a positive test result or refused to take a DOT drug or alcohol **pre-employment test** within the past two years from a motor carrier who did not hire you? **YES or NO**

if the answer to the above questions is yes, please list the motor carrier(s) below:

Name of Motor Carrier: _____

Address: _____

Telephone No.: _____

In addition, if the answer to the above question was YES, please list the name and contact information for the Substance Abuse Professional (SAP) who completed your evaluation.

Name of SAP: _____

Address: _____

Telephone No.: _____

Signature of applicant

Date