

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

LOCATION	DATE	CHARGE	PENALTY

(ATTACH SHEET IF MORE SPACE IS NEEDED)

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

IF THE ANSWER TO EITHER A OR B ABOVE IS YES, ATTACH STATEMENT GIVING DETAILS

EMPLOYMENT RECORD

Note: DOT Requires That Employment for at least 3 Years and/or Commercial Driving Experience for the Past 10 Years Be Shown

Last Employer:

Name _____

Address _____

Position Held _____ FROM _____ TO _____

Reason For Leaving _____

Second Last Employer:

Name _____

Address _____

Position Held _____ FROM _____ TO _____

Reason For Leaving _____

Third Last Employer:

Name _____

Address _____

Position Held _____ FROM _____ TO _____

Reason For Leaving _____

TO BE READ AND SIGNED BY 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.

_____ Date

_____ Applicant's Signature

Note: A motor carrier may require an applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present

in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers (Form M-274)*. You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

- A.** If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B.** If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C.** If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:
1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
 2. Record the document title, document number, and expiration date (if any) in Block C; and
 3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3**.

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address <i>(Street Name and Number)</i>		Apt. #	Date of Birth <i>(month/day/year)</i>
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature	Date <i>(month/day/year)</i>
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Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address <i>(Street Name and Number, City, State, Zip Code)</i>	
Date <i>(month/day/year)</i>	

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date <i>(if any)</i> : _____		_____		_____
Document #: _____		_____		_____
Expiration Date <i>(if any)</i> : _____		_____		_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address <i>(Street Name and Number, City, State, Zip Code)</i>		Date <i>(month/day/year)</i>

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name <i>(if applicable)</i>	B. Date of Rehire <i>(month/day/year)</i> <i>(if applicable)</i>
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____	Document #: _____	Expiration Date <i>(if any)</i> : _____
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date <i>(month/day/year)</i>
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

**Documents that Establish
Employment Authorization**

	OR	
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
4. Employment Authorization Document that contains a photograph (Form I-766)		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
	3. School ID card with a photograph	4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
	4. Voter's registration card	
	5. U.S. Military card or draft record	5. Native American tribal document
	6. Military dependent's ID card	
	7. U.S. Coast Guard Merchant Mariner Card	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	8. Native American tribal document	6. U.S. Citizen ID Card (Form I-197)
	9. Driver's license issued by a Canadian government authority	
	For persons under age 18 who are unable to present a document listed above:	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

EMPLOYEE DRIVING RECORD AUTHORIZATION

It is the policy of **REYNOLDS ASPHALT & CONSTRUCTION COMPANY** to check the driving record of employees who may operate a company motor vehicle. You are being asked to consent to a **DRIVING RECORD** check and periodic checks in the future. By signing the following statement you are giving your consent to the periodic checks.

I do hereby appoint and / or assign **REYNOLDS ASPHALT & CONSTRUCTION COMPANY** to conduct or commission periodic checks of my driving record. I agree to indemnify and release **REYNOLDS ASPHALT & CONSTRUCTION COMPANY** and its agents from any and all liability for claims, damages, losses or actions resulting from or arising from its investigation, except as such may be caused by or arise out of the gross negligence or unauthorized act of either party. I understand that an adverse driving record may be grounds for reassignment or termination of employment.

I have read the above statement and accept the same as a condition of my employment with **REYNOLDS ASPHALT & CONSTRUCTION COMPANY**.

Texas Drivers License #

Date of Birth (Month/Day/Year)

Signature

Date

Printed Name

Witness

Form W-4 (2010)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent **A** _____

B Enter "1" if: } } **B** _____

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

C Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) **E** _____

F Enter "1" if you have at least \$1,800 of **child or dependent care expenses** for which you plan to claim a credit **F** _____

(Note. Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children. **G** _____

H Add lines A through G and enter total here. **(Note.** This may be different from the number of exemptions you claim on your tax return.) **H** _____

For accuracy, **complete all worksheets that apply.** } }

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 2010
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____ 6 \$ _____
6 Additional amount, if any, you want withheld from each paycheck		
7 I claim exemption from withholding for 2010, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

- 1** Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions **1** \$ _____
- 2** Enter:

{	\$11,400 if married filing jointly or qualifying widow(er)	}	2	\$ _____
	\$8,400 if head of household				
	\$5,700 if single or married filing separately				
- 3** **Subtract** line 2 from line 1. If zero or less, enter “-0-” **3** \$ _____
- 4** Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919) **4** \$ _____
- 5** **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.) **5** \$ _____
- 6** Enter an estimate of your 2010 nonwage income (such as dividends or interest) **6** \$ _____
- 7** **Subtract** line 6 from line 5. If zero or less, enter “-0-” **7** \$ _____
- 8** **Divide** the amount on line 7 by \$3,650 and enter the result here. Drop any fraction **8** _____
- 9** Enter the number from the **Personal Allowances Worksheet**, line H, page 1 **9** _____
- 10** **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1** Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1** _____
- 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3.” **2** _____
- 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3** _____

Note. If line 1 is **less than** line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4–9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- 4** Enter the number from line 2 of this worksheet **4** _____
- 5** Enter the number from line 1 of this worksheet **5** _____
- 6** **Subtract** line 5 from line 4 **6** _____
- 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here **7** \$ _____
- 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed **8** \$ _____
- 9** Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** \$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$7,000 -	0	\$0 - \$6,000 -	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
7,001 - 10,000 -	1	6,001 - 12,000 -	1	65,001 - 120,000	910	35,001 - 90,000	910
10,001 - 16,000 -	2	12,001 - 19,000 -	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
16,001 - 22,000 -	3	19,001 - 26,000 -	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 27,000 -	4	26,001 - 35,000 -	4	330,001 and over	1,280	370,001 and over	1,280
27,001 - 35,000 -	5	35,001 - 50,000 -	5				
35,001 - 44,000 -	6	50,001 - 65,000 -	6				
44,001 - 50,000 -	7	65,001 - 80,000 -	7				
50,001 - 55,000 -	8	80,001 - 90,000 -	8				
55,001 - 65,000 -	9	90,001 -120,000 -	9				
65,001 - 72,000 -	10	120,001 and over	10				
72,001 - 85,000 -	11						
85,001 -105,000 -	12						
105,001 -115,000 -	13						
115,001 -130,000 -	14						
130,001 - and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



REYNOLDS ASPHALT AND CONSTRUCTION CO.

PO Box 370 Euless, Texas 76039

Metro (817) 267-3131

FAX (817) 267-1878

DEAR EMPLOYEE AND ELIGIBLE DEPENDENTS:

PLEASE READ THE ATTACHED FORMS AND FILE WITH YOUR INSURANCE PAPERS.

PLEASE SIGN AND DATE THIS ACKNOWLEDGEMENT OF RECEIPT AND RETURN TO MELANI MARTIN AT THE MAIN OFFICE.

ENCLOSED:

1. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)
2. NEW HIRE NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
3. NEW HIRE NOTICE OF SPECIAL ENROLLMENT RIGHTS
4. NEW HIRE NOTICE OF PRE-EXISTING CONDITIONS LIMITATIONS
5. NEW HIRE NOTICE OF NEWBORN'S AND MOTHER'S PROTECTION ACT OF 1996
6. MODEL NOTICE OF EMPLOYEE'S RIGHTS TO CONTINUE GROUP HEALTH COVERAGE

THANK YOU,

BILL EVANS
HEALTH AND LIFE INSURANCE REPRESENTATIVE

BCBS

NAME

DATE



**Workers' Compensation Health Care Network
Employee Acknowledgment Form**

I have received information that tells me how to get medical care under workers' compensation insurance. I understand that my employer uses the **First Health/Travelers Health Care Network (HCN)**.

If I have a work-related injury or illness and I live in the Network Service Area described in this information, then I understand that:

1. I am required to choose a treating doctor from the list of doctors in the HCN.
Note: There is only one exception to this requirement, which applies if I am covered by an HMO for my Group Health benefits. In that case, I may choose my HMO Primary Care Physician (PCP) to serve as my treating doctor. My PCP must agree to all the requirements of the HCN. I must check one of the following boxes:
 - I choose my HMO PCP to provide any medical care related to a work-related injury or illness. I will call the HCN at 1-866-245-6472 and tell the HCN the name of my PCP, or,
 - I do not choose my HMO PCP to provide any medical care related to a work-related injury or illness.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.

(Employee Signature) _____
(Date)

(Printed Name)

I live at _____
(Street Address)

(City) (State) (ZIP Code)

Name of Employer: _____

Name of Network: First Health/Travelers HCN

**The Network Service Area is subject to change.
If you need a treating provider call the HCN at: 1- 866-245-6472.
PLEASE RETURN THE COMPLETED FORM TO YOUR EMPLOYER**

Formulario de Acuse de Recibo por el Empleado de Información sobre la Red de Cuidado de Salud (HCN) de Compensación por Lesiones de Trabajo

He recibido información que me notifica cómo obtener cuidado médico bajo el seguro de compensación por lesiones de trabajo ("Workers' Compensation" por su nombre en inglés). Entiendo que mi empleador utiliza **la Red de Cuidado Médico First Health Travelers**.

Si me lesiono en el trabajo y vivo en el área de servicio descrita en esta información, entiendo que:

1. Debo escoger un médico tratante de la lista de médicos de la red del HCN.

Nota: Hay solamente una excepción a este requisito que se aplica si estoy cubierto por un HMO en mi grupo de beneficios médicos. En ese caso, puedo elegir a mi médico primario del cuidado de HMO (PCP) que sirva como mi doctor de tratamiento. Mi PCP debe adherir a todos los requisitos del HCN. Debo escoger una de las siguientes:

- Elijo a mi HMO PCP para que proporcione cualquier asistencia médica relacionada con una lesión o enfermedad relacionada con el trabajo. Llamaré al HCN al 1-866-245-6472 y le diré a HCN el nombre de mi PCP (médico primario del cuidado) o,
- No elijo a mi HMO PCP para que proporcione ninguna asistencia médica relacionada con una lesión o una enfermedad relacionada con el trabajo.

2. Debo acudir a mi médico tratante para recibir cualquier y toda atención médica por mi lesión. En caso de necesitar un especialista, mi médico tratante me derivará. Si necesito cuidado de urgencia, puedo buscar atención médica en cualquier lugar.

3. La compañía de seguro pagará al médico tratante y a los otros profesionales de la red.

4. Es posible que yo tenga que pagar la factura si recibo atención médica de personas ajenas a la red sin aprobación previa de la HCN.

(Firma)

(Fecha)

(Nombre y apellido en letra de molde)

Vivo en _____
(Domicilio)

(Ciudad) (Estado) (Código postal)

Nombre de la compañía: _____

Nombre de la Red: First Health/Travelers HCN

**El área de servicio de la red está sujeta a cambios.
Si usted necesita un profesional médico tratante llame a la HCN al: 1-866-245-6472.
DEVUELVA ESTE FORMULARIO COMPLETADO A SU COMPAÑÍ**

Mạng Lưới Chăm Sóc Sức Khỏe Bồi Thường Tai Nạn Lao Động Mẫu Xác Nhận Của Nhân Viên

Tôi đã nhận được hướng dẫn cách có được dịch vụ chữa trị theo diện bảo hiểm bồi thường tai nạn lao động. Tôi biết là hãng sở của tôi sử dụng **First Health/Travelers Health Care Network (HCN)**.

Nếu tôi gặp một thương tích hay căn bệnh liên quan tới công việc và tôi cư ngụ trong Khu Vực Phục Vụ của Mạng Lưới như trình bày trong tờ thông tin này, thì tôi hiểu rằng:

1. Tôi phải lựa chọn một bác sĩ điều trị trong danh sách các bác sĩ của HCN.

Lưu ý: Chỉ có một trường hợp ngoại lệ đối với yêu cầu này, và ngoại lệ này sẽ áp dụng nếu tôi nhận bảo hiểm Sức Khỏe Theo Nhóm qua HMO. Trong trường hợp đó, tôi có thể chọn Bác Sĩ Chăm Sóc Chính HMO của tôi (PCP) là bác sĩ điều trị. PCP của tôi phải đồng ý với tất cả các yêu cầu của HCN. Tôi phải đánh dấu vào một trong các ô sau đây:

- Tôi chọn PCP trong HMO của tôi cho các dịch vụ điều trị liên quan tới một thương tích hoặc căn bệnh liên quan tới công việc. Tôi sẽ gọi HCN tại số 1-866-245-6472 để thông báo tên PCP của tôi, hoặc,
- Tôi không chọn PCP trong HMO của tôi cho các dịch vụ điều trị liên quan tới một thương tích hoặc căn bệnh liên quan tới công việc.

2. Tôi phải nhận toàn bộ dịch vụ chữa trị cho thương tích của tôi qua bác sĩ điều trị. Nếu tôi cần bác sĩ chuyên khoa, bác sĩ điều trị của tôi sẽ giới thiệu tôi. Nếu tôi cần chăm sóc cấp cứu, tôi có thể tới bất kỳ đâu.

3. Hãng bảo hiểm sẽ trả tiền cho bác sĩ điều trị và các nhà cung cấp dịch vụ khác trong mạng lưới.

4. Tôi có thể phải trả chi phí nếu chữa trị qua người khác không phải là bác sĩ trong mạng lưới khi chưa được mạng lưới cho phép.

(Chữ Ký Của Nhân Viên)

(Ngày)

(Tên Viết Bằng Chữ In)

Tôi cư ngụ tại

(Địa Chỉ Đường Phố)

(Thành Phố)

(Tiểu Bang)

(Số ZIP Code)

Tên của Hãng Sở: _____

Tên của Mạng Lưới: First Health/Travelers HCN _____

**Khu Vực Phục Vụ của Mạng Lưới có thể thay đổi.
Nếu bạn cần bác sĩ điều trị, xin gọi HCN tại: 1- 866-245-6472.
VUI LÒNG GỬI LẠI MẪU ĐƠN ĐÃ ĐIỀN CHO HÃNG SỞ CỦA BẠN**



REYNOLDS ASPHALT AND CONSTRUCTION CO.

PO Box 370 Euless, Texas 76039

Metro (817) 267-3131

FAX (817) 267-1878

NOTIFICATION OF DRUG AND ALCOHOL POLICY

EFFECTIVE DATE: January 1, 2003

Because of growing concern regarding the effects of alcohol and drug abuse in the workplace, the potential adverse impact of such abuse on employees, the safety of employees and to comply with federal laws such as the Department of Transportation's Federal Highway Administration Substance Abuse policy, Reynolds Asphalt and Construction Company (RAC) has developed a Substance Abuse Policy for our employees.

Use and misuse of alcohol or drugs can and does impair the ability of an employee to perform their duties. Such abusive activity may endanger the employee, his/her co-workers, company property, and the public at large. Reynolds Asphalt and Construction Company will try to prevent the use, misuse, and or abuse of substances which impair the employee's ability to perform their duties.

Therefore, in the interest of safety for the employee and their fellow co-workers, it is the policy of RAC to require urine drug testing and alcohol testing under the circumstances outlined in RAC's Substance Abuse Policy.

Each employee and candidate for employment is hereby notified of the following:

Safety and efficiency make enforcement of the Substance Abuse Policy a pre-requisite to providing a safe and productive workplace for all employees and our customers.

Drug and alcohol testing is part of RAC's Substance Abuse Policy, as are possible searches. Drug and alcohol testing will begin as of the effective date of this policy. The testing program was designed as a deterrent to continued abuse, and encouragement to seek help before personal problems affect job performance, and to help overcome an individual's natural tendency to deny there is a problem.

RAC has taken the necessary precautions to ensure the accuracy of all tests.

RAC will test all candidates for new hire and rehire. All applicants who fail to pass a drug test will have their employment offers revoked by RAC.

ALL OFFERS OF EMPLOYMENT ARE EXPRESSLY CONTINGENT UPON NEGATIVE DRUG TEST RESULTS.

Employees who are suspected of a violation of the Substance Abuse Policy will be tested. Any individual involved in either an on-the-job accident that causes injury to a person, including themselves, or destruction of property will be tested.

ANY EMPLOYEE WHO REFUSES A DRUG OR ALCOHOL TEST WILL BE TERMINATED.

This is only a notice and does not contain all the provisions of the Substance Abuse Policy adapted by RAC. All employees are expected to educate themselves on the policy and must agree to abide by the policy as a condition of continued employment with RAC. A complete copy of RAC's Substance Abuse Policy is attached for personnel reference and is on file with the Substance Abuse Program Manager (Bill Evans). RAC retains the privilege to make changes or revisions to any part or parts of this policy without further notice and at any time which are binding on all current employees.

Gary E. Reynolds
Gary E. Reynolds, President

December 2, 2002

EMPLOYEE ACKNOWLEDGMENT FOR FHWA/DOT & NON-DOT

I acknowledge that I have received a copy of the RAC Drug and Alcohol Policy. I also acknowledge that the provisions of the policy are part of the terms and conditions of my employment and that I agree to abide by them. In addition, my signature below constitutes voluntary consent to RAC's request for me to provide urine, breath and blood samples for Department of Transportation testing under 49CFR Part 382 and 40 and/or under RAC's Substance Abuse Program. I fully understand that failure to cooperate will result in termination or the offer of employment being withdrawn.

THIS COPY TO BE MAINTAINED IN THE PERSONNEL FILE

Signature of Employee

RAC Witness

Print Name

Date

Employee Social Security #

Driver Qualification File Checklist

The following documents are to be included in a DQ file for duration of employment:

- Driver-specific application for employment (§391.21)

- Original Motor vehicle record (MVR) requested from states within 30 days of hire (§391.23)
- Road test or road test exception
- Road test form and certificate conducted by your motor carrier (§391.31(g))
or
- Road test certificate conducted by another motor carrier within the past 3 years (§391.33(a)(2))
or
- Photocopy of a CDL accepted in lieu of road test - not applicable if hired to operate doubles, triples, or tankers. (Note: No subsequent copies of license renewals required.) (§391.33(a)(1))
- Background investigations (§391.23)
- Drivers hired before October 30, 2004: General employment verifications sent to all former employers for the 3 years prior to the application date or a record of a good faith effort
or
- Drivers hired on or after October 30, 2004: Safety Performance History data from all former DOT-regulated employers for the 3 years prior to the application date or a record of a good faith effort. This form must be maintained in accordance with §391.53 (secured, limited access) and may be in a separate Driver Investigation History File; and if applicable, any driver rebuttals to the Safety Performance History data and responses to the rebuttals from the former DOT-regulated employers.
- The following documents are to be included in the DQ file for three years from date of execution:
 - Medical certification (§391.43(g)):
Medical exam certificate, original or a copy, for all non-CDL drivers
or
 - Medical exam certificate, original or a copy, for CDL drivers whose states have not adopted the rules linking the CDL with the medical examination
or
- Current MVR from the state showing medical qualification for CDL drivers whose states have adopted the rules linking the CDL with the medical examination
- If applicable, any letter granting a waiver of a physical disqualification (§391.49(j))
- Annual motor vehicle record (§391.25)
- Annual review of driving record (§391.25)
- Annual list of violations (§391.27)
- The DQ file and Driver Investigation History file are retained for 3 years after a driver leaves your employment.
- The following documents are also required and kept in the DQ file, but are not applicable to all drivers:
 - Longer Combination Vehicle (LCV) Driver-Training Certificate (§380.401); and
 - entry-level driver training certificate (§380.509(b)).



RELEASE OF CDL HOLDER'S REPORTED POSITIVE ALCOHOL OR CONTROLLED SUBSTANCE TEST RESULTS



Use this form to obtain the CDL holder's reported positive alcohol or controlled substance test results information.

This form should **ONLY** be used if you wish to inquire whether or not a prospective driver (CDL Holder) has had a positive alcohol or controlled substance test result reported to the Texas Department of Public Safety in compliance with state law.

THIS FORM IS NOT REQUIRED FOR REPORTING A POSITIVE ALCOHOL OR CONTROLLED SUBSTANCE TEST.

1. This form must be completed in full and include the driver's original signature.
2. Deliver, mail or FAX the completed form to:

**Texas Department of Public Safety
Motor Carrier Bureau, MSC# 0522
6200 Guadalupe, Building P
Austin, Texas 78752-4019
Facsimile: 512-424-5310**

I, _____
Print Name of CDL Holder

of _____
Print Address of CDL Holder

authorize release of the CDL holder's reported positive alcohol or controlled substance test results reported under state law

to _____
Print Name

of _____
Print Address

Driver License Number: _____ State: _____ Date of Birth: _____

Signature of Driver:

Date:

X

If you wish to request and receive this information by electronic mail, submit a completed and notarized Electronic Mail Verification Form (MCS-32), available at the following web address: <http://www.txdps.state.tx.us/forms/index.htm>.

Release of DOT Drug & Alcohol Testing Information
49 CFR Part 40

Section I. To be completed by the new employer, signed by the employee, and transmitted to the previous employer:

Employee Printed or Typed Name: _____

Employee SS or ID # _____

I hereby authorize release of information from my Department of Transportation regulated drug and alcohol testing records by my previous employer, listed in *Section I-B*, to the employer listed in *Section I-A*. This release is in accordance with DOT Regulation 49 CFR Part 40, Section 40.25. I understand that information to be released in *Section II-A* by my previous employer, is limited to the following DOT-regulated testing items:

1. Alcohol tests with a result of 0.04 or higher
2. Verified positive drug tests
3. Refusals to be tested
4. Other violations of DOT agency drug and alcohol testing regulations
5. Information obtained from previous employers of a drug and alcohol rule violation
6. Documentation, if any, of completion of the return-to-duty process following a rule violation

Employee Signature: _____ Date: _____

I-A.

New Employer Name: Reynolds Asphalt & Construction Company, Inc.

Address: 701 S. Industrial Blvd, Ste 100 Euless, TX 76040

Phone #: (817) 267-3131

Fax#: (817) 267-1878

Designated Employer Representative: Monte Hood

I-B.

Previous Employer Name: _____

Address: _____

Phone #: _____

Designated Employer Representative (if known): _____

Section II. To be completed by the previous employer and transmitted by mail or fax to the new employer:

II-A. In the three years prior to the date of the employee's signature (in Section I), for DOT-regulated testing

1. Did the employee have alcohol tests with a result of 0.04 or higher? YES ___ NO ___
2. Did the employee have verified positive drug tests? YES ___ NO ___
3. Did the employee refuse to be tested? YES ___ NO ___
4. Did the employee have other violations of DOT agency drug and alcohol testing regulations? YES ___ NO ___
5. Did a previous employer report a drug and alcohol rule violation to you? YES ___ NO ___
6. If you answered "yes" to any of the above items, did the employee complete the return-to-duty process? N/A ___ YES ___ NO ___

NOTE: If you answered "yes" to item 5, you must provide the previous employer's report. If you answered "yes" to item 6, you must also transmit the appropriate return-to-duty documentation (e.g., SAP report(s), follow-up testing record).

II-B.

Name of person providing information in *Section II-A*: _____

Title: _____ Phone #: _____ Date _____

REQUEST FOR INFORMATION FROM PREVIOUS EMPLOYER

FROM: **Reynolds Asphalt & Construction Company, Inc.**

TO: _____ DATE _____

SOCIAL SECURITY NUMBER: _____

_____ has made application to this company for a position as _____

And states that he/she was employed by you as _____ from _____ to _____

Will you please reply to the inquiry below respecting this applicant? Your reply will be held in strict confidence and will in no way involve you in any responsibility.
For you convenience in replying by return mail, we have enclosed a stamped self-addressed envelope.

Very truly yours,

Safety Department

1. Is the employment record with your company correct as stated above? _____
2. What kind(s) of work did the applicant do? _____
3. Did the applicant drive motor vehicles for you? Passenger car Straight truck Bus
Tractor Semi trailer
Other (specify) _____
4. Was the applicant a safe and efficient driver? _____
5. Give the dates of vehicle accidents in which he/she was involved. _____
6. Reason for leaving your employ: Discharge
Laid off
Resigned
7. Was the applicant's general conduct satisfactory?
8. Is the applicant competent for the position sought? _____
9. Did the applicant drink any alcoholic beverages while on duty? _____

(Please Circle)

Quality of Work	Excellent	Good	Fair	Poor	Very Poor
Cooperation with Others	Excellent	Good	Fair	Poor	Very Poor
Safety Habits	Excellent	Good	Fair	Poor	Very Poor
Personal Habits	Excellent	Good	Fair	Poor	Very Poor
Driving Skills	Excellent	Good	Fair	Poor	Very Poor
Attitude	Excellent	Good	Fair	Poor	Very Poor

Remarks: _____

Date: _____ Signature: _____

Name of Company: _____

_____ **Date:** _____
(Name of Former Employer)

You are hereby authorized to release to Reynolds Asphalt & Construction Company, all information regarding my services, character, and conduct while in your employ, and you are released from any and all liability which may result from furnishing such information to the above named company.

Applicant's Signature

Date

REQUEST FOR CHECK OF DRIVING RECORD

I hereby authorize you to release the following information to _____
(Prospective Employer)
for purpose of investigation as required by Sections 391.23 and 391.25 of the Federal Motor Carrier Safety Regulations. You are released from any and all liability which may result from furnishing such information.

(Applicant's Signature) (Date)

In accordance with the provisions of Sections 604 and 607 of the **Fair Credit Reporting Act**, Public Law 91-508, as amended by the Consumer Credit Reporting Act of 1996 (Title 11, Subtitle D, Chapter 1, of Public Law 104-208), I hereby certify the following:

1. The consumer (applicant) has authorized in writing the procurement of this report;
2. The consumer (applicant) has been informed in a separate written disclosure that a consumer report may be obtained for employment purposes;
3. The information requested below will be used for a "permissible purpose" (i.e., information for employment purposes) and will be used for no other purpose;
4. The information being obtained will not be used in violation of any federal or state equal opportunity law or regulation; and
5. Before taking an adverse action based in whole or in part on the report the consumer (applicant) will receive a copy of the requested report and the summary of consumer rights as provided with the report by the consumer reporting agency.

I also hereby certify that this report request and the above applicant's release notice meet the definition of "permissible uses" of state motor vehicle records under the provisions of the **Driver's Privacy Protection Act of 1994** (Public Law 103-322, Title XXX, Section 300002(a)).

(Signature of Requester) (Date)

TO: _____

DEAR SIR/MADAM:

The Following named person has made application with our company for the position of _____
_____ In accordance with Section 391.23, Federal Department of Transportation Regulations, please furnish the undersigned with the applicant's driving record for the past tree years.

The following named person is employed with our company in the position of _____
_____ In accordance with Section 391.25, Federal Department of Transportation Regulations, please furnish the undersigned with the employee's driving record for the past year.

NAME OF APPLICANT/DRIVER _____

ADDRESS _____
(Number & Street) (City) (State) (Zip Code)

FORMER ADDRESS _____
(Number & Street) (City) (State) (Zip Code)

DATE OF BIRTH _____ SSN _____ LICENSE NO. _____

REQUESTED BY

(Name of Company) (Typed Name)

(Address) (Title)

(City) (State) (Signature)

CERTIFICATION OF COMPLIANCE WITH DRIVER LICENSE REQUIREMENTS

The requirements in Part 383 apply to every driver who operates 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 driver 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.

DRIVER REQUIREMENTS: Parts 383 and 391 of the Federal Motor Carrier Safety Regulations contain some requirements that you as a driver must comply with. These requirements are in effect as of July 1, 1987. They are as follows:

1. **POSSESS ONLY ONE LICENSE:** You, as a commercial vehicle driver, may not possess more than one motor vehicle operator's license.

If you have more than one license, keep the license from your state of residence and return the additional license 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, close your record by notifying the state of issuance that you no longer want to be licensed by the state.

2. **NOTIFICATION OF LICENSE SUSPENSION, REVOCATION OR CANCELLATION:** Sections 392.42 and 383.33 of the Federal Motor Carrier Safety Regulations require that you notify your employer the NEXT BUSINESS DAY of any revocation or suspension of your driver's license.

In addition, Section 383.31 requires that any time you violate a state or local traffic law (other than parking), you must report it within 30 days to : 1) your employing carrier, and 2) the state that issued your license (if the violation occurs in a state other than the one which issued your license). The notification to both the employer and state must be in writing.

The following license is the only one I will possess:

Driver's License No. _____ State _____ Expiration Date _____

DRIVER'S CERTIFICATION: I certify that I have read and understand the above requirements.

Driver's Name (Printed): _____

Driver's Signature: _____ Date _____

Reviewed by: _____
Carrier Official (printed) _____ Date _____

Carrier Signature _____ Title _____

Carrier

Comments: _____

SUMMARY OF HOURS WORKED AND HOURS AVAILABLE

This summary page may be used either separately or in conjunction with the Redi Recap section on the face of each record of duty status to assist the driver in computing his or her time. Entries should be made each day even though driver may not work on a particular day or days. The record of "Total On Duty Hours, under heading PREVIOUS MONTH'S REFERENCE representing the last 7 days previous month" right side of this page may be used to assist in computing the hours at the beginning of each month. These figures are necessary when using this page only or when recording hours of service on each record of duty status.

DATE	Hours worked today	Total Hours Last 6 Days	Total Hours Last 7 Days	Eligible Hours Tomorrow	PREVIOUS MONTH'S REFERENCE		
					Date	Record of Duty Status No.	Total On Duty Hours
1							
2							
3							
4							
5							
6							
7							
8							
9							
10						TOTAL	
11							
12							
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