

**APPLICATION FOR EMPLOYMENT**

GREEN/FORM NO.

**DQF**  
**1**

Have all driver-applicants complete this form before driving a commercial motor vehicle.

In compliance with Federal and State equal opportunity employment laws, qualified applicants are considered for all positions without regard to race, religion, color, gender, national origin, age, marital status, or non-job related disability. Please complete both sides of this application thoroughly. Attach additional sheets if more room is required for details.

**To be completed by Employer:**

Motor Carrier:
Address:

**To be completed by Applicant:**

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

PREVIOUS ADDRESSES FOR LAST THREE YEARS (MOST RECENT FIRST)				
Street	City	State/Zip	How long	Additional Information Attached <input type="checkbox"/>

LIST ALL UNEXPIRED LICENSES AND/OR PERMITS			
State	Number	Expiration Date	Additional Information Attached <input type="checkbox"/>
<i>VA</i>	<i>B66171331</i>	<i>7/18/20</i>	

LIST THE NATURE AND EXTENT OF YOUR EXPERIENCE OPERATING DIFFERENT TYPES OF MOTOR VEHICLES (E.G. BUSES, TRUCKS & TRAILERS)		
Type	Experience in Years and / or Miles Driven	Additional Information Attached <input type="checkbox"/>
<i>Tractor / Trailer</i>	<i>18</i>	
<i>Bus</i>	<i>10</i>	

LIST ALL MOTOR VEHICLE ACCIDENTS IN WHICH YOU WERE INVOLVED DURING THE LAST THREE YEARS				
DATE	CITY/STATE	NATURE OF ACCIDENT	FATALITIES	INJURIES

☒ Check here to certify that you have had no accidents in the last three years

LIST ALL VIOLATIONS (OTHER THAN PARKING) FOR WHICH YOU WERE CONVICTED OR FORFEITED BOND / COLLATERAL DURING THE LAST THREE YEARS			
DATE	CITY/STATE	CHARGE	PENALTY

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

**DQF 1 - APPLICATION FOR EMPLOYMENT**Retain for 3 years  
after ceasing duties



# APPLICATION FOR EMPLOYMENT

**PLEASE DETAIL THE FACTS AND CIRCUMSTANCES OF ANY DENIAL, REVOCATION, OR SUSPENSION OF ANY LICENSE, PERMIT, OR PRIVILEGE TO OPERATE A MOTOR VEHICLE:**

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☐ Check here to certify that no such denial, revocation or suspension has occurred

## EMPLOYMENT HISTORY

Please complete all information regarding prior employers during the last three years. If you are applying to operate a Commercial Motor Vehicle (GVWR of 10,001 lbs. or more, ability to transport 8 or more people, or any vehicle requiring placarding for hazardous materials), please include complete information regarding prior employers for the last 10 years for whom you operated such vehicles. Please start with your most recent prior employer (Use additional sheets if necessary).

Employer Name: <u>US Army</u>	Employed From: <u>4/11/96</u>	To: <u>1/2017</u>
Address:	Position: <u>Driver instructor</u>	
	Salary:	
Contact: Phone: <u>703 696 6469</u>	Reason for Leaving: <u>retired</u>	
Were you subject to the Federal Motor Carrier Safety Regulations while employed by this employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Was your position "safety-sensitive" requiring Part 40 drug and alcohol testing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

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

## OFFICE USE ONLY

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

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

Applicant Signature: [Signature]

**SIGN HERE**

Date: 5 May 2017



**RECEIPT OF DRIVER'S RIGHTS**

PURPLE/FORM NO.

**SPH**  
**1**

Have each driver-applicant sign this form before you accept his/her employment application.

Employers who are regulated by the Federal Motor Carrier Safety Administration (FMCSA) must expressly notify an applicant, who has been employed by a Department of Transportation-regulated employer during the preceding three years, that the applicant has certain rights regarding the investigative information that will be provided by his/her previous employer(s). After providing the driver-applicant with a written copy of these rights, use this form to obtain his/her signature and retain the top copy of this 2-part form. Give the bottom copy to the applicant. By regulation you must inform the driver of his/her rights **before** accepting the driver's application for employment.

**DRIVER REVIEW AND RECEIPT**

☐ I acknowledge that \_\_\_\_\_ has provided me with written  
*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).

*Bodney Livatt*  
 Driver's Full Name

*Ronze*  
 Driver's Signature

**SIGN HERE**

*5 May 2017*  
 Date

**SIGN HERE**

Supervisor/Authorized Motor Carrier Representative Signature

Date

**Employer Keeps Original, Provides Scan or Copy to Applicant**



**SAFETY PERFORMANCE HISTORY INVESTIGATION**

GREEN/FORM NO.

**SPH  
2/3/R**

Use ONE form to investigate applicant's Safety Performance History (SPH) for EACH employer within the previous three years. Three forms provided, make copies as necessary.

**TO BE COMPLETED BY APPLICANT:**

As the applicant, my signature authorizes you, as my previous employer, to release the requested information to Foley Carrier Services, LLC., the service vendor used by my prospective employer,

Applicant's Name: Anthony Livata Social Security Number: 240 256 3012 Client Code: \_\_\_\_\_

Applicant's Signature: [Signature] Previous Employer: \_\_\_\_\_

**TO BE COMPLETED BY PREVIOUS EMPLOYER:**

FMCSA regulations require this SPH investigation. Please complete the requested information, using additional paper if necessary. If you have no information to report, please indicate so in the appropriate section. Email completed information to: [BSS@FoleyServices.com](mailto: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





10124584

4946280

SPECIMEN ID NO.

**STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE**

LAB ACCESSION NO.

**A. Employer Name, Address, I.D. No.**
 RBY SALMON TRUCKING  
RBY SALMON  
9737 EUSTICE ROAD  
RANDALLSTOWN MD 21133  
PH: 443-629-4648 FAX: --
**B. MRO Name, Address, Phone No. and Fax No.**
 FREDERICK J POPE, MD, MRO  
FOLEY MRO SERVICES  
140 HUYSHOPE AVE  
HARTFORD CT 06106  
PH: 860-815-0825 FAX: 860-920-5260
**C. Donor SSN or Employee I.D. No.**
**D. Specify Testing Authority:** ☐ HHS ☐ NRC ☒ DOT - Specify DOT Agency: ☒ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

**E. Reason for Test:** ☒ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-up ☐ Other (specify)

**F. Drug Tests to be Performed:** ☒ THC, COC, PCP, OPI, AMP ☐ THC & COC Only ☐ Other (specify)

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

**G. Collection Site Name:**

Collection Site Code:

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

 Collector Phone No.: 410-247-9515  
Collector Fax No.: 410-247-7553
**STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate) Collector reads specimen temperature within 4 minutes.**
 Temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark Collection: ☐ Split ☐ Single ☐ None Provided, Enter Remark ☐ Observed, (Enter Remark)  
REMARKS
**STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)****STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY**

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

 X *[Signature]*  
Signature of Collector

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

Date (Mo./Day/Yr.)

Time of Collection

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

Name of Delivery Service

**STEP 5: COMPLETED BY DONOR**

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

 X *[Signature]*  
Signature of Donor

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

Date (Mo./Day/Yr.)

Daytime Phone No. 570 315 9797

Evening Phone No. ( )

Date of Birth 7/18/75

After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). - DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.

**STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN**

In accordance with applicable Federal requirements, my verification is:

☒ **NEGATIVE** ☐ **POSITIVE** for:☐ DILUTE☐ **REFUSAL TO TEST** because - check reason(s) below:☐ ADULTERATED (adulterant/reason):☐ SUBSTITUTED☐ OTHER☐ **TEST CANCELLED**

REMARKS:

X

Signature of Medical Review Officer

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

Date (Mo./Day/Yr.)

**STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN**

In accordance with applicable Federal requirements, my verification for split specimen (if tested) is:

☐ **RECONFIRMED** for:☐ **FAILED TO RECONFIRM** for:☐ **TEST CANCELLED**

REMARKS:

X

Signature of Medical Review Officer

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

Date (Mo./Day/Yr.)