



**James Brown Contracting, Inc. DBA Brown Trucking Company**

**DRIVER'S APPLICATION FOR EMPLOYMENT**

**6908 Chapman Road Lithonia, GA 30058**

**1-800-241-5624 WATS**

**770-482-6521 Local**

**770-482-3872 Fax**

**In compliance with Federal and State Equal Opportunity laws, qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital status, or non-job related disability. Brown Trucking Company is a Drug-Free Workplace. Please answer all questions – please print. A 7 year MVR must accompany this application.**

Date of Application : \_\_\_\_\_ Position applied for: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Last First MI

Current Address: \_\_\_\_\_  
Street City State Zip How long at address?

List your addresses for the past 3 years:

\_\_\_\_\_  
Street City State Zip How long at address?

Previous

\_\_\_\_\_  
Street City State Zip How long at address?

Addresses

\_\_\_\_\_  
Street City State Zip How long at address?

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have the right to work in the United States?  YES  NO

Can you provide proof of age?  YES  NO

Have you worked for this company before?  YES  NO

Which location? \_\_\_\_\_ Date: From: \_\_\_\_\_ to: \_\_\_\_\_

Reason for leaving? \_\_\_\_\_

Are you currently employed?  YES  NO How long since leaving last employment? \_\_\_\_\_

Expected rate of pay \_\_\_\_\_ Who referred you? \_\_\_\_\_

**How can we contact you?**

Home phone number: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

**Emergency Contact Name and phone number:** \_\_\_\_\_

This driving position may include heavy lifting, tailgating, etc.; is there any reason that you may not be qualified to perform the functions of the job you applied for? \_\_\_\_\_

**Education**

Circle Highest Grade Completed 1 2 3 4 5 6 7 8 High School 1 2 3 4 College 1 2 3 4 +

Last school attended: \_\_\_\_\_  
Name City



## EMPLOYMENT HISTORY

All driver applicants to drive in interstate commerce must provide information on all employers in the past 3 years. Please provide complete information. Applicants to drive a commercial motor vehicle (GVWR of 26,001 lbs. or more, vehicles designed to transport 15 or more passengers, or any size vehicle used to transport hazardous materials in a quantity requiring placarding) in intrastate or interstate commerce shall also provide an additional 7 years information on those employers for whom the applicant operated such a vehicle. Please list employers beginning with the most recent. Attach additional sheets if necessary.

EMPLOYER			DATES	
NAME:			FROM:	TO:
ADDRESS:			POSITION:	
CITY:	STATE:	ZIP:	SALARY/WAGE:	
CONTACT PERSON:		PHONE NUMBER:	REASON FOR LEAVING:	
WERE YOU SUBJECT TO THE FMCSRS* WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO				
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO				
EMPLOYER			DATES	
NAME:			FROM:	TO:
ADDRESS:			POSITION:	
CITY:	STATE:	ZIP:	SALARY/WAGE:	
CONTACT PERSON:		PHONE NUMBER:	REASON FOR LEAVING:	
WERE YOU SUBJECT TO THE FMCSRS* WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO				
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO				
EMPLOYER			DATES	
NAME:			FROM:	TO:
ADDRESS:			POSITION:	
CITY:	STATE:	ZIP:	SALARY/WAGE:	
CONTACT PERSON:		PHONE NUMBER:	REASON FOR LEAVING:	
WERE YOU SUBJECT TO THE FMCSRS* WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO				
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO				
EMPLOYER			DATES	
NAME:			FROM:	TO:
ADDRESS:			POSITION:	
CITY:	STATE:	ZIP:	SALARY/WAGE:	
CONTACT PERSON:		PHONE NUMBER:	REASON FOR LEAVING:	
WERE YOU SUBJECT TO THE FMCSRS* WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO				
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO				

\*The Federal Motor Carrier Safety Regulations (FMCSRs) apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle: (1) weighs or has a GVWR of 10,001 pounds or more, (2) is designed or used to transport 9 or more passengers, OR (3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.





**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.

I authorize you to make such investigations and inquiries of my personal, employment, financial or medical history and other related matters as may be necessary in arriving at an employment decision. Generally, inquires 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 liabilities in responding to inquiries and releasing information in connection with my application.

In the event of employment, I understand that false or misleading information given in my application or interviews may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Company.

I understand that information I provide regarding current and/or previous employers may be used, and those employer(s) will be contacted, for the purpose of investigating my safety performance history as required by 49 CFR 391.23(d) and (e). I understand that I have the right to:

- a) Review information provided by previous employers
- b) Have errors in the information corrected by previous employers and for those previous employers to re-send the corrected information to the prospective employer; and
- c) Have a rebuttal statement attached to the alleged erroneous information, if the previous employer(s) and I cannot agree on the accuracy of the information.

In the event of employment is terminated before 90 days, I will be charged for the cost of the physical and drug screen.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
APPLICANT'S SIGNATURE

**Owner/Operator Unit Information:**

Year: \_\_\_\_\_

Make: \_\_\_\_\_

Model: \_\_\_\_\_

Date of Purchase: \_\_\_\_\_

Purchase Price: \$ \_\_\_\_\_

(What YOU paid for the truck)





REQUEST/CONSENT FOR INFORMATION FROM PREVIOUS EMPLOYER ON ALCOHOL & CONTROLLED SUBSTANCES TESTING

SECTION 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name) \_\_\_\_\_ First, MI, Last \_\_\_\_\_ Social Security Number \_\_\_\_\_

Hereby authorize that:

Previous employer: \_\_\_\_\_

Street address: \_\_\_\_\_ Telephone \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Fax number \_\_\_\_\_

may release and forward information requested by Section 2, below, of this document concerning my Alcohol and Controlled Substances Testing records for the previous three (3) years from: \_\_\_\_\_ (Date of employment application)

Prospective Employer: James Brown Contracting, Inc. DBA Brown Trucking Company 770-482-6521 Telephone
Attention: Safety and Recruiting
Address: 6908 Chapman Road, Lithonia, GA 30058 770-482-3872 Fax number

Applicant: Sign here only -> \_\_\_\_\_ Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

The release of this information should be made by letter or fax to the above in order to maintain confidentiality. This is in compliance with Part 40.25 and 391.23.

SECTION 2: TO BE COMPLETED BY PREVIOUS EMPLOYER

DRUG AND ALCOHOL HISTORY

If driver was not subject to Part 382 testing requirements while employed by this employer, please check here [ ], show dates of employment from \_\_\_\_\_ to \_\_\_\_\_, complete bottom of this section and return.

Dates driver was subject to DOT testing requirements: From: \_\_\_\_\_ To: \_\_\_\_\_

- 1. Has this person ever had an alcohol test with a Breath Alcohol Concentration 0.04 or greater? YES NO
2. Has this person tested positive or adulterated or substituted a test specimen for controlled substances? YES NO
3. Has this person ever refused a required test for drugs or alcohol? YES NO
4. Has this person committed other violations of Subpart B of Part 382, or Part 40? YES NO
5. If this person has violated a DOT drug and alcohol regulation, did this person complete a SAP-prescribed rehabilitation program in your company, including return-to-duty and follow-up test? YES NO
6. For a driver who successfully completed a SAP's rehabilitation referral and remained in your employ, did this driver subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refuse to be tested? YES NO

In answering these questions, include any required DOT drug or alcohol testing information obtained from previous employers in the previous three (3) years prior to the application date shown above.

NAME: \_\_\_\_\_
COMPANY: \_\_\_\_\_
STREET: \_\_\_\_\_
CITY, STATE, ZIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_
Section 2 Completed by (Signature): \_\_\_\_\_ Date: \_\_\_\_\_



**SECTION 3: TO BE COMPLETED BY PREVIOUS EMPLOYER  
ACCIDENT HISTORY**

The applicant named in SECTION 1 above was employed by us.  YES  NO

The applicant was employed as \_\_\_\_\_. From \_\_\_\_\_ to \_\_\_\_\_  
Start Date End Date

1. Did applicant drive a motor vehicle for you? YES  NO  If yes, what type vehicle? Straight Truck  Tractor-Semitrailer  Bus  Double/Triples  Other(specify) \_\_\_\_\_

2. Reason for leaving your employ: Discharged  Resigned  Lay off  Military Duty

If there is no safety performance history to report, check here  sign below and return.

**ACCIDENTS:** List any accident(s) listed on your accident register that involved the applicant for the three years prior to the application date shown above. If no accidents, enter "NONE".

Date	Location	# of injured	# of fatalities	Hazmat Spill
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Please list below information concerning other accident(s) involving the applicant which were reported to government agencies, insurers or retained under company policy:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any remarks concerning the applicant's safety/accident history would be appreciated:

\_\_\_\_\_  
 \_\_\_\_\_

Signature of provider: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

**SECTION 4a: TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

This form was (check one)  Faxed to previous employer  Mailed to previous employer  Email to previous employer

By: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 4b: TO BE COMPLETED BY PROSPECTIVE EMPLOYER**

***Complete below when information is obtained.***

Information received from: \_\_\_\_\_

Recorded by: \_\_\_\_\_ Method:  Fax  Mail  Email  Telephone

Date: \_\_\_\_\_