Must Have Copies of the Following

1. Twic Card
2. Driver License
3. Social Security Card
4. Medical Card
5. Voided Check
6. Print out from DMV of driving record

BBSI

APPLICATION for CO-EMPLOYMENT

LAST NAME	FIRST NAME	MI

MAILING ADDRESS	CITY	STATE	ZIP CODE

STREET ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE

COUNTY OF RESIDENCE	HOME PHONE	MESSAGE / CELL PHONE

EMAIL ADDRESS	EMERGENCY CONTACT: NAME / PHONE

HAVE YOU EVER HAD A SECURITY CLEARANCE? ☐YES ☐NO	WHERE?	WHEN?	LEVEL?

HAVE YOU BEEN CONVICTED OF A FELONY IN THE LAST 7 YEARS ☐YES ☐NO (CA applicants need not list marijuana possession crimes older than 2 years.)	IF YES, PLEASE EXPLAIN	ARE YOU AT LEAST 18 YEARS OLD? ☐YES ☐NO
HAVE YOU EVER APPLIED WITH BBSI BEFORE? ☐YES ☐NO	IF YES, GIVE DATE / BRANCH	IF NO, DO YOU HAVE A WORK PERMIT? ☐YES ☐NO

EMPLOYMENT HISTORY

CURRENT EMPLOYER	TITLE / POSITION

EMPLOYEE ID #	DEPARTMENT	DATE OF HIRE

EMPLOYER (1)	TITLES / DUTIES
ADDRESS	

SUPERVISOR	PAY RATE	DATES TO

TELEPHONE	REASON FOR LEAVING

COMMENTS

EMPLOYER (2)	TITLES / DUTIES
ADDRESS	

SUPERVISOR	PAY RATE	DATES TO

TELEPHONE	REASON FOR LEAVING

COMMENTS

EMPLOYER (3)	TITLES / DUTIES
ADDRESS	

SUPERVISOR	PAY RATE	DATES TO

TELEPHONE	REASON FOR LEAVING

COMMENTS

EDUCATION

		INSTITUTION	CITY, STATE	FIELD OF STUDY
	High School Grad			
	Trade School			
	GED			
	AA/AS Degree			
	BA/BS Degree			
	Masters			
	Ph.D.			

SUMMARY of POLICIES

AT-WILL EMPLOYMENT

Employment at your Worksite Employer and Barrett Business Services, Inc. (BBSI) is "AT-WILL". The employment relationship may be terminated for any reason with or without cause or notice at any time by you or either Company. No oral statement shall limit the right to terminate employment at-will.

EQUAL EMPLOYMENT PRACTICES

BBSI is an equal opportunity employer and makes employment decisions on the basis of merit. BBSI's policy prohibits unlawful discrimination based on race, disability, medical condition, veteran status, sexual orientation or any other consideration made unlawful by federal, state or local laws. BBSI's commitment to equal opportunity employment applies to all persons involved in the operations of the company and prohibits unlawful discrimination by any employee, including supervisors and co-workers.

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with disabilities, BBSI will make reasonable accommodations for the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee unless undue hardship would result.

If BBSI determines that unlawful discrimination has occurred, remedial action will be taken, commensurate with the severity of the offense. Appropriate action will also be taken to deter any future discrimination. BBSI will not retaliate against you for filing a complaint and will not knowingly permit retaliation by management employees or your co-workers.

UNLAWFUL HARASSMENT, SEXUAL HARASSMENT AND WORKPLACE VIOLENCE

BBSI does not tolerate harassment, sexual harassment or violence of any type to our employees, clients, vendors or suppliers. Any form of harassment which is prohibited by the Equal Employment Opportunity Commission and which violates federal, state or local law, including, but not limited to, harassment related to an individual's race, religion, color, sex, sexual orientation, national origin, ancestry, citizen status, marital status, pregnancy, age, medical condition, handicap or disability is a violation of this policy. Any employee who engages in any of the acts or behavior described below, is subject to employee disciplinary action, up to and including immediate discharge.

- **HARASSMENT:** Verbal, physical or visual conduct of a racial, ethnic or other type which, in the employee's opinion, impairs his or her ability to perform the job.

- **SEXUAL HARASSMENT:** Sexual harassment includes unwelcome sexual advances or visual, verbal or physical conduct of a sexual nature. This definition encompasses many forms of offensive behavior, including gender-based harassment of a person of the same sex as the harasser, conduct of a sexual nature that creates an offensive, intimidating or hostile work environment and coerced sexual conduct by a person in a position of authority.

- **VIOLENCE:** Any behavior that could be construed as violent in nature or any physical action that is intimidating or violent to any person.

Complaints of harassment of any type should be reported immediately, without fear of reprisals, to both your Worksite Employer AND to BBSI. Confidentiality will be maintained to the extent permitted by the circumstances.

ELECTRONIC DATA SYSTEMS

BBSI and/or Worksite Employer may maintain a voice-mail system, an electronic mail (e-mail) system or various other systems to assist in the conduct of business. These systems, including the equipment and the data stored in the system are, and remain at all times, the property of BBSI and/or Worksite Employer. As such, all messages created, sent, received or stored in the system are and remain the property of BBSI and/or Worksite Employer. All information and data maintained by BBSI and/or Worksite Employer should be considered confidential BBSI and/or Worksite Employer information and should not be disclosed to unauthorized personnel.

Messages should be limited to the conduct of BBSI and/or Worksite Employer business. Voice-mail and electronic mail may not be used for the conduct of personal business and may be reviewed by BBSI and/or Worksite Employer.

EMPLOYEE EXPENSE REIMBURSEMENTS

At the express written request of a Worksite Employer, BBSI, on behalf of the Worksite Employer, will make allowances, advance funds, or reimburse Employees for expenditures made by Employees in connection with services performed for or on behalf of the Worksite Employer.

The Worksite Employer shall maintain and administer an accountable plan for all advances, allowances, or reimbursements made to Employees. Any advances, allowances, or reimbursed expenses paid to the Employees are considered as made by the Worksite Employer and pursuant to the Worksite Employer's accountable plan. BBSI is the Worksite Employer's paying agent in connection with Worksite Employer's accountable plan.

BBSI does not and shall not maintain an accountable plan for the Employees of the Worksite Employer.

ALCOHOL and DRUG POLICY STATMENT

Concern for employees' safety and health has always been and continues to be a major commitment of BBSI ("the Company"). The Company expects all employees to assist in maintaining a work place free from alcohol and drugs.

POLICY

Buying, selling, giving, receiving, possession or use of, or impairment from illegal drugs, while on Company premises, during work hours or meal breaks is not permitted. This includes all behavior-altering substances that could influence job performance. Impairment from or use of alcohol while on Company premises or during work hours is not permitted. Employees are expected to be in suitable mental and physical condition at work, free from all influences of alcohol and drugs.

An employee who is using prescription or over-the-counter drugs that may impair the employee's ability to safely perform the job, or affect the safety or well-being of others, must notify a supervisor of such use immediately before starting or resuming work.

Violations of this policy are grounds for disciplinary action, up to and including termination of employment or denial of employment.

MEDICAL EVALUATIONS, SCREENING AND TESTING

CONSENT FORM: A signed consent form is to be obtained from an applicant or employee before a test, screen, or evaluation is conducted.

APPLICANTS: The Company reserves the right to screen, test and otherwise evaluate for alcohol and drug abuse. If a drug screen result is "inconclusive", the applicant has the option to undergo a clinical test or decline going further in the application process. If the clinical test results are positive the applicant is not to be hired and must pay for the test. If the clinical test results are negative, the normal application process may be resumed and the Company will pay for the test.

EMPLOYEES: The Company reserves the right to test, screen, and otherwise medically evaluate all employees for alcohol and drug abuse. This may be done on a probable cause, post-injury, random, or systematic basis, where lawful, at any time the Company decides to do so. When an employee is screened and the results are "inconclusive" the employee is to be immediately suspended from work and removed from the work site until clinical test results return. When an employee is clinically tested and the results are positive, the employee is to be terminated. If the results are negative from the clinical test, the employee is to be paid for any time missed because of the suspension and be returned to his/her previous position.

REFUSALS: A refusal to submit to screening, testing, or evaluations will render the same results as if the confirmation test produced a positive result, namely, ineligibility for hire, and if currently an employee, termination of employment.

TAMPERING: Tampering or attempting to tamper with a specimen sample will render the same results as if a confirmation test produced a positive result, namely, ineligibility for hire, and if currently an employee, termination.

This policy in no way should be construed as an employment contract of any kind, implied or otherwise.

SEARCHES

The Company specifically reserves the right to carry out reasonable searches of personal effects and vehicles when individuals are entering, while on, and leaving company premises including, but not limited to, all occupied or vacant, land, buildings, structures, installations, automobiles, trucks, and all other company owned or leased property. Submission to such a search is voluntary; however, refusal may be cause for expulsion from premises, and if an employee, discipline up to and including termination of employment.

ACKNOWLEDGEMENT and AGREEMENT

I have been informed of my Worksite Employer's agreement with Barrett Business Services Inc. (BBSI) for Professional Employer Services. I understand that I will be co-employed by my Worksite Employer and BBSI. My signature below acknowledges that I have been informed of this fact and am in agreement with it.

I understand that nothing contained in this employment application creates a contract between the company and myself for employment or any other benefit. No promises regarding employment have been made to me and I understand that no such promise or guarantee is binding upon the company. If an employment relationship is established, I understand that my employment is at-will and my employment and compensation can be terminated with or without cause, and with or without notice, at any time, at the option of either the company or myself. I further understand that no representative of the company, other than the president of the company, has any authorization to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing and any such agreement to the contrary must be in writing and signed by the president. I also understand that I am required to abide by all of the rules and regulations of the company.

If I am ever injured on the job or unable to perform my job duties because of a job related injury, I agree to immediately report the facts TO BOTH my Worksite Employer and BBSI. I agree to immediately report to BBSI in order to perform any modified work as assigned.

My signature on this employment application authorizes my Worksite Employer and/or BBSI to investigate all statements and information given on this application and to check my professional and personal references to verify the accuracy of information I disclosed in this application, a related employment resume or a personal interview. To assist in the processing of my Application, I waive all rights and claims I may otherwise have against the employer or its representatives, for seeking and using information to evaluate my employment request and all other persons, corporations or organizations who provide information for this purpose.

I understand and agree that falsification of information, misleading statements, misrepresentation, or omission of facts on this or other Worksite Employer or BBSI employment forms, is cause for denial of employment or if employed, cause for dismissal regardless of when discovered.

BBSI does not discriminate among applicants or employees on the basis of race, color, age, sex, religion, national origin, marital status, sexual orientation, the presence of medical conditions or disability, or any other legally protected status. BBSI is not an employment agency.

SIGNATURE: _____ DATE: _____

Payroll Election Form

BBSI
A Human Resource Management Company

✓ Worksite Employer: Extreme Transported Date ✓
✓ Employee Name (print): ✓
✓ Employee Signature: Social Security #. ✓

☐ **New Enrollment**	☐ **Enroll in Direct Deposit to a Visa Payroll Card:** You will receive your personalized PaychekPLUS! Elite® Visa® Payroll Card in 7 –10 business days from your Manager or Payroll Administrator. ☐ **Deposit $_____ on each pay date (Enter "Net" if electing to deposit all net pay)** By checking this box, you are choosing to have your pay direct deposited on a Visa payroll card and agree to the following: Consent to Payroll Card Account: I hereby designate MetaBank™ as my financial institution to accept the direct deposit of my wages from my employer into an account at MetaBank. I choose to receive a payroll card in my name issued by MetaBank for the purpose of accessing my wages from my Payroll Card account. I acknowledge that third parties other than MetaBank may impose fees and charges in connection with the use of the Payroll Card; however, I understand that I may choose one of several transactions each pay period, which are outlined in the Cardholder Terms and Conditions, by which I can withdraw my entire net pay without the payment of a fee. I declare the foregoing to be true and complete to the best of my knowledge. I authorize Company to deposit my wages each payday directly into my Payroll Card account. This authority remains in effect until I have given written notice by writing to BBSI, Payroll Administrator that I revoke it terminated. If funds to which I am not entitled are deposited into my Card Account, I authorize BBSI to direct MetaBank to return said funds. I also understand that it is my responsibility to verify deposits prior to any transaction against the Card balance.
✓	☒ **Enroll in Direct Deposit to a Bank Account:** Please complete the section above and attach a voided check, or a copy of a voided check, or a printed confirmation of the ABA Transit Routing Number and your Account Number as it should appear in BBSI's payroll database. ☐ **Deposit $_____ on each pay date to my:** *(Enter "Net" if electing to deposit all net pay into this account)* Name of Financial Institution: _____ *ABA Transit Routing Number AND Account Number* _____ ☐ Checking ☐ Savings Account ☐ **Deposit my remaining (if any) net pay to:** *ABA Transit Routing Number AND Account Number* _____ ☒ Checking ☐ Savings Account
☐ **Change Enrollment**	**Change in Direct Deposit:** For any changes to original enrollment, please check this box and make the changes in the spaces provided above. A voided check, copy of a voided check or a printed confirmation of the ABA Transit Routing Number and your account number must be attached if you change financial institutions.
☐ **Cancel Enrollment**	**Cancel Direct Deposit Option:** Please indicate effective Date of Cancellation: _____

If you do not wish to participate in Direct Deposit please contact your BBSI representative for instructions.

I hereby authorize BBSI and the financial institution listed above to initiate entries into the account number listed on this Agreement. In the event that the financial institution is notified by BBSI that funds to which the employee is not entitled to have been deposited in error to the above listed account, I authorize the financial institution to return such funds to BBSI.

Please note: To ensure prompt and accurate processing of enrollment/change request, forward all employee applications including a voided check (no deposit slips) to BBSI as soon as completed. This agreement may only be terminated as outlined in the CANCEL DIRECT DEPOSIT option listed above. Direct Deposits will typically be effective within 14 days from the date this form is received by BBSI.

If you do not choose one of the direct deposit options above, and you do not complete the Direct Deposit Opt Out form on the reverse, you will automatically receive a Visa payroll card.

The PaychekPLUS! Elite Visa Payroll Card is issued by MetaBank™ pursuant to a license from Visa U.S.A. Inc.

***Direct Deposit into a Bank Account will not be entered without one of the below items. (Not available for Visa Payroll Card.)*

ATTACH
Voided Check OR Bank Printout of Account and ABA Routing Number**
No Deposit Slips

Printed Name Signature Date Rev 6-2010

Form W-4 (2017)

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 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't 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 can 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. 505 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. 505 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. 505 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. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

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: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
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 $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
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 $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	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 are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 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.

---------- **Separate 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

Employee's Withholding Allowance Certificate

▶ **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.**

OMB No. 1545-0074

2017

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ 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.** ▶ ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • 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 (This 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 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $

2 Enter: { $12,700 if married filing jointly or qualifying widow(er) / $9,350 if head of household / $6,350 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) . . . . . 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2017 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 $4,050 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 Form W-4, line 5, page 1 10

also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1

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 through 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 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. 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

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
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
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 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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 to the Department of Health and Human Services for use 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

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 hea from you. See the instructions for your income tax return.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date*(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

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	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**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
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

SICK LEAVE

In order to help prevent loss of earnings that may be caused by accident, illness, or other emergencies, the Company has established paid sick leave.

Eligibility

This sick leave policy applies to all employees, other than staffing agency workers.

Use

Sick leave may be taken for:

(a) Diagnosis, care, or treatment of an existing health condition of, or preventative care for, an employee or an employee's family member.

(b) Leave pursuant to the Company's leave of absence policy for victims of domestic violence, sexual assault, or stalking.

For purposes of this policy, "family member" is defined to include any of the following persons in relation to the employee: (a) child; (b) parent, stepparent, or legal guardian of the employee or the employee's spouse, or registered domestic partner; (c) spouse or registered domestic partner; (d) grandparent or grandchild; (e) sibling.

If the need for sick leave is foreseeable, the employee must provide reasonable advance notification before taking sick leave. If the need for sick leave is unforeseeable, the employee shall provide notice of the need for leave as soon as practicable. Usage of sick leave is limited to 24 hours per year of employment.] Sick leave must be taken by eligible employees in increments of at least 2 hours. Exempt employees will receive their regular pay, and do not need to use sick leave, for absences of less than [a full work day] [four hours in a work day].

Compensation For Sick Leave

Eligible employees will receive pay at their normal hourly wage for any sick leave taken. If the employee in the 90 days of employment before taking sick leave had different hourly rates, was paid by commission or piece rate, or was a non-exempt salaried employee, then the sick leave rate of pay will be calculated by dividing the employee's total wages, not including overtime premium pay, by the employee's total hours worked in the full pay periods of the prior 90 days of employment

No employee will receive pay in lieu of sick leave under any circumstances, and employees will not be paid for any unused sick leave upon termination of employment.

Yearly Allotment

The Company provides the following amount of sick leave that may be used during the 12-month period measured July 1st through June 30th.

- Regular full-time employees: 24 hours.
- Regular part-time employees: 24hours.
- Temporary employees: 24 hours.

For clarity, the above yearly allotment resets each such 12-month period. Any unused portion does not carry over to the next 12-month period.

Employees may not use paid sick leave days until the 90th day of employment.

Coordination of Sick Leave Benefits With Other Benefits

The Company will pay any available sick leave benefits to an eligible employee during the normal three-day waiting period before the employee is paid workers' compensation benefits pursuant to the applicable state or federal law governing the industrial injury or illness.

Similarly, the Company will pay any available sick leave benefits during the normal seven-day waiting period before the eligible employee is paid benefits from the State Disability Insurance (SDI) program or other insured unemployment disability plan.

Following the three-day and seven-day waiting periods specified above, an employee will continue to receive any available sick pay, less the disability benefits actually received or the disability benefits that would have been received had the employee made timely application to the appropriate agency.

NOTICE TO EMPLOYEE

Labor Code section 2810.5

This form is not intended to alter the at-will nature of your employment, which means the employment relationship can be terminated at-will by any party, at any time, with or without cause or advance notice.

EMPLOYEE

Employee Name: _____ Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: Extreme Transportation Inc

Other Names Employer is doing business as (if applicable): _____

Physical Address of Main Office 2434 Southport Way, F, National City CA 91950

Employer's Mailing Address (if different than above): _____

Employer's Telephone Number: 619-292-2830

The Company outsources certain employer related functions to Barrett Business Services, Inc. (BBSI). BBSI's main office or principal place of business is located at 8100 NE Parkway Drive, Suite 200, Vancouver, WA 98662. BBSI's phone number is (360) 828-0700.

WAGE INFORMATION

Rate(s) of Pay: 23% gross Overtime Rate(s) of Pay: _____

Rate by (check box): ☐ Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece rate ☐ Commission

☐ Other (provide specifics): _____

Does a written agreement exist providing the rate(s) of pay? (check box): ☐ Yes ☒ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? ☐ Yes ☐ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):

_____

(If the employee has signed the acknowledgment of receipt below, it does not constitute a voluntary written agreement as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Pay Day: 1st & 15th

WORKERS' COMPENSATION

Workers' compensation coverage is provided through Ace American Insurance Co. The contact information for the program is as follows: CorVel Corporation, P.O. Box 277550, Sacramento, CA 95827. The phone number is (916) 605-3800.
Current policy number: _____.

Any work related injuries or accidents should be immediately reported to your supervisor and the Company is to contact BBSI immediately thereafter. You will be required to submit to post-accident drug/alcohol testing to the extent permitted by law.

PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
   1. requesting or using accrued sick days;
   2. attempting to exercise the right to use accrued paid sick days;
   3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
   4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: (Check one box)

☐ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.

☐ 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.

☒ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.

☐ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption): _____

ACKNOWLEDGMENT OF RECEIPT

Nikki K Peterson
(PRINT NAME of Employer representative)

Nikki K Peterson
(SIGNATURE of Employer representative)

(Date)

(PRINT NAME of Employee)

(SIGNATURE of Employee)

(Date)

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing require by law within seven days of the changes.

A Human Resource Management Company

Barrett Business Services, Inc.

EMPLOYEE ACKNOWLEDGEMENT OF THE MEDICAL PROVIDER NETWORK

In order to provide the most timely and suitable quality medical care in the event of an injury on the job, we have instituted a Medical Provider Network for Workers' Compensation purposes.

The following procedures must be followed for all work related injuries and illnesses.

- Report promptly any work related injury to the supervisor.
- For a referral to a medical provider specialist, contact your employer or claims adjuster.
- Ensure all medical treatment is handled only through the MPN (Medical Provider Network) unless otherwise authorized.
- Direct all questions about the level of care to the PCP (Primary Care Physician), who is the focal point for all medical treatment.
- A directory of medical care providers is available at my request through my employer.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury and your duties under our Medical Provider Network.

Print Name _____ Date _____

Employee Signature _____ Employer _____

Employee Number (Optional) _____

A COPY OF THE MPN DIRECTORY IS AVAILABLE FROM YOUR EMPLOYER OR ADJUSTER UPON YOUR REQUEST.

A Human Resource Management Company

Barrett Business Services, Inc.

RECONOCIMIENTO DEL EMPLEADO DE LA MEDICAL PROVIDER NETWORK

Para brindar atención médica de la más rápida y de apropiada calidad en el evento de una lesión ocasionada en el trabajo, hemos instituido una Red de Proveedores Médicos para propositos de Compensación Laboral.

Los procedimientos siguientes deben ser seguidos para todas las lesiones y enfermedades ocasionadas en el trabajo.

- Reporte inmediatamente a su supervisor cualquier lesión ocasionada en el trabajo.
- Para una referencia a un médico especialista, comuníquese con su empleador o ajustador de reclamos.
- Cerciórese que todo tratamiento médico sea manejado únicamente por la MPN (Red de Proveedores Médicos), a menos que de otro modo autorizado
- Dirija toda pregunta sobre el nivel de cuidado al PCP (Primary Care Physician – Médico de Cabecera), quien es el punto de referencia para todo tratamiento médico.
- Un directorio de proveedores de cuidado médico está disponible al solicitarlo a través de mi empleador.

Por favor firmar abajo para indicar que usted ha leído y entendido los procedimientos que se siguen en el evento de una lesión y sus responsabilidades bajo nuestra Red de Proveedores Médicos.

Nombre en Imprenta _____ Fecha _____

Firma del Empleado _____ Empleador _____

Número del Empleado (opcional) _____

UNA COPIA DEL DIRECTORIO DE LA MPN ESTA DISPONIBLE DE SU EMPLEADOR O AJUSTADOR AL SOLICITARLO.

CMCI DRIVER REGISTRATION FORM

Fax to 816-229-0518 or email to CMCI@OOIDA.COM

Call 800-288-3784 to pay for CMCI and set up the Pre-Employment test if necessary.

MUST BE LEGIBLE & FILLED OUT ENTIRELY TO BE PROCESSED. USE BLACK INK.

Company Info

Membership # 487170

Company Name Extreme Transportation Inc.

Company Owner Name James & Nikki Perham

Company Address 24134 Southport Way, F

City National City State CA Zip 91950

Phone number 619-292-2830

Driver Info

Driver's License #	State Issued	Membership #

Driver's Full Name

Mailing Address

City State Zip

Phone# Alt Phone #

Social Security # Date of Birth

Does this driver hold a CDL? Y Yes ___ No

This driver is an : ___Leased Owner-Operator ___Hired Driver/Contract

If Owner Operator/Leased Driver. # Trucks owned? _____ Own Trailer? ___Yes ___ No

Has driver ever tested positive OR refused a controlled substance test? ___Yes ___ No

If YES, did driver complete Return to Duty Process? ___Yes ___ No

If YES. can driver provide SAP/Return to Duty information to the Motor Carrier? ___Yes ___ No

Request/Consent for information from previous employer

Must complete one form for each employer for the last 3 years

Section 1: To be completed by driver

Driver Name:_____ **SSN:** _____

Previous Employer or Service Agent: _____

Address:_____ **City/State/Zip:** _____

Phone# _____ **Fax#** _____

I _____ **hereby authorize that the above company may release and forward information:**
(applicants signature)
requested by section 2 (below) of this document concerning my Alcohol and Controlled Substance Testing records to the employer below

Prospective Employer: _____

Mailing Address: _____

Phone Number:_____ **Fax Number:** _____

I understand that the information to be released by my previous employer or service agent is limited to the DOT regulated testing items listed in section 2 (below). This release is in accordance with DOT Regulation 49 CFR Part 40 and Part 391.

Section 2: To be completed by previous employer

If driver was NOT subject to DOT testing requirements while employed by this employer, please check here ☐

Employment Dates: From_____ **to** _____

Has the driver ever refused a required DOT drug or Alcohol test?	**Yes**	**No**
Has the driver ever tested positive on a DOT required controlled substance test?	**Yes**	**No**
Has the driver ever tested at or above 0.04 on any DOT required alcohol test?	**Yes**	**No**
Has the driver ever violated any other provisions of the DOT drug and alcohol testing regulations?	**Yes**	**No**
Have you received information from any previous employer that this individual violated DOT drug and alcohol regulations?	**Yes**	**No**

Date the driver was last tested for alcohol? _____/_____/_____

Date driver was last tested for drugs? _____/_____/_____

Section 2 completed by (signature)_____ **Date:** _____

Print Name_____ **Title**_____

Phone number:_____

This form was (check one) ☐ Faxed ☐ Mailed to previous employer Date_____**&**_____

Complete the fields below when the information is obtained:

Information received from:_____ **Date:**_____

Recorded by: _____ **Title:**_____

Information received by: ☐**Fax** ☐**Mail** ☐**Phone** ☐**Personal interview**

DRIVER NOTICE

PAPERWORK

ALL paperwork must be in the office every MONDAY AM!!!! NO EXCEPTIONS.

EXTRA PASSENGERS

Effective Immediately: Non - Employee's of Extreme Transportation Inc. are **NOT** allowed to ride in company trucks, drive or pull cars, help load or unload vehicles on or off trailer. This includes all family members, friends etc. This is an insurance issue and will NOT be allowed.

Please sign and return this letter acknowledging you have read, understand and will follow these regulations.

_____ _____

Driver Signature Date

Extreme Transportation Inc
400 Mile of Cars Way
Ste C
National City CA 91950
(619) 292-2830
(951)346-3760 Fax

Driver's Notice

(Company Drug &Alcohol Policy)

Please read carefully: This is a company driver's notice to inform you that here at Extreme Transportation Inc. has a **NO** tolerance policy to testing positive to any types of drugs or alcohol. This means you will be terminated immediately as a driver from Extreme Transportation Inc.

If Extreme Transportation Inc. decides to keep you employed after testing positive you will have to go through a drug and alcohol substance class that will be recommended to you by our drug management company (CMCI). You will not be eligible to drive until course is complete and a new drug & alcohol test is completed with a negative result.

This letter must be signed by you the driver and returned immediately to office. This shows that you have read and completely agree to all terms of being employed as a driver by Extreme Transportation Inc.

Nikki Perham - V.P. Date

Driver Date

Extreme Transportation Inc.
2525 Southport Way
Suite B
National City CA 91950
619-292-2830

Driver Notice

Several texts and verbal notifications have gone out regarding Vin #'s, Damage Reports etc.
This is to clearly STATE there will be ZERO exceptions on the following:

1. **Vin#** on unit is short (need last 8) you will NOT be paid for unit unless the correct Vin# is provided... No guessing of numbers!

2. **Lost keys** to units are 100% drivers responsibility to keep in there safe possession until unit is delivered. Lost

keys to cars will be at drivers expense NOT Extreme Transportation Inc.

3. **Inspections** - drivers must do a complete inspection of vehicles. If Extreme Transportation Inc. receives a claim for such vehicles and the original documentation does NOT show a driver inspection it will be 100% of the drivers responsibility to pay for damaged vehicle. You all have been made aware of this policy time and time again. Our vendors expect and demand inspections of vehicles. Every military vehicle hauled must have the current mileage noted on paperwork. Truck #, Driver Name (Clearly Written) Date....

We are not out there with each and every one of you when you load. These all are considered drivers responsibility of transporting someone's vehicle. Please sign and return to office by fax, mail or email ASAP that you have read and understand notice.

Drivers
Signature:_____ Date:_____

Extreme Transportation Inc.'s

Driver Safety Notice & Procedures

Drivers:

1. Must wear NON-Slip enclosed shoes (NO Tennis Shoes)
2. Gloves (No Jewelry)
3. Safety Vest (Wear when required)
4. Extreme work shirts & jackets (Only)

Please **slow down** and take all precautions when loading & unloading vehicles. Be aware of your surroundings, this is for your own **SAFETY!**

Loading Procedures:

1. Do NOT drive fast in yards!!!!!!!!!!
2. Check that all vehicles are tied down properly
3. NO loading of convertibles, camper shells or trucks with tonneau covers backward on trailer **(Not following this procedure of loading will result in severe damages! If discovered that these types of vehicles were loading improper and caused damage you will be terminated immediately.)**
4. Avoid if possible from loading convertible on bottom of trailers

Truck Gear:

1. Jump Boxes (If you don't have one in the truck now because you have left it somewhere, you are allowed to go get ONE more. Next one will be one you!)
2. Kitty Litter (This is for oil leaks etc. must have for yards)
3. Triangle safety cones

Paperwork Requirement:

1. Must have if you want to get paid for load:
    A. **Date**
    B. **Truck Number**
    C. **Driver Signed Name**
    D. **Full address of pick-up & drop off locations**
    E. **Complete inspections of vehicles**

Please sign and return to office. This ensures that you have read and understand this notice.

Driver's Signature:_____ **Date:**_____

EMPLOYEE RESPONSIBILITY AND ACKNOWLEDGMENT

I understand that it is my responsibility to comply with and observe all company safety and health rules and apply the principles of accident prevention in my day-to-day duties as outlined in this Employee Safety Handbook and the Code of Safe Practices contained within this document.

I agree to cooperate fully with my employer's safety programs and initiatives, follow all safety rules, and to report any unsafe work conditions to my employer and injuries to my employer and BBSI immediately upon discovery.

✓ **I have been shown the location of the following (✓all that apply):**

- ○ Fire Extinguishers
- ○ First Aid Kits
- ○ Material Safety Data Sheets
- ○ Emergency Exits
- ○ Restrooms
- ○ Designated Break/Lunch Areas

✓ **I have been issued the following (✓all that apply):**

- ○ Safety Glasses
- ○ Face Shield
- ○ Respirators/Dust Masks
- ○ Aprons/Chaps
- ○ Shoes
- ○ Fall Protection Equipment
- ○ Hearing Protection
- ○ Gloves/Hand Protection
- ○ Hard Hat/Head Protection

✓ **I have read the Employee Safety Handbook and completed the following:**

- ○ Safety Quiz
- ○ Other: _____
- ○ Other: _____
- ○ Other: _____

Employee Section

✓ _____ _____ _____ ✓

Employee's Name (Print) Employee's Signature Date

✓ _____ _____

Employee's Social Security Number Employment Start Date

Manager/Supervisor/Trainer Section

_____ _____ _____

Manager/Trainer Name (Print) Manager/Trainer Signature Date