HAWAII PETROLEUM

Ohana FUELS | MINIT STOP | HFN

DRIVER EMPLOYMENT APPLICATION

MAUI: 385 Hukilike Street, #102 | Kahului, Hawaii 96732

HILO: 16 Railroad Avenue, #202 | Hilo, Hawaii 96720

An Equal Opportunity Employer

Carriers do not need to use this exact form, but must have a completed and signed employment application for all drivers that contains the information listed in 49 CFR 391.21.

COMPLETE IN FULL OR IT WILL NOT BE CONSIDERED.

APPLICANT INFORMATION						
FIRST NAME		MIDDLE NAME		LAST NAME		
PHONE		EMAIL				
DATE OF BIRTH		SOCIAL SECURITY #				
DATE OF APPLICATION		POSITION APPLIED FOR		DATE AVAILABLE FOR WORK		

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

PREVIOUS THREE YEARS RESIDENCY					
Attach additional sheet if more space is needed					
	STREET	CITY	STATE	ZIP CODE	# OF YEARS AT ADDRESS
CURRENT					
MAILING					
PREVIOUS					
PREVIOUS					
PREVIOUS					

LICENSE INFORMATION				
No person who operates a commercial motor vehicle shall at any time have more than one driver's license (49 CFR 383.21). I certify that I do not have more than one motor vehicle license, the information for which is listed below. Include all licenses held for the past 3 years; attach additional sheets if needed.				
STATE	LICENSE #	TYPE/CLASS	ENDORSEMENTS	EXPIRATION DATE
PREVOIUSLY HELD LICENSES				

DRIVING EXPERIENCE				
CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.)	DATE FROM	DATE TO	APPROX # OF MILES (TOTAL)
STRAIGHT TRUCK				
TRACTOR & SEMI-TRAILER				
TRACTOR & 2 TRAILERS				
TRACTOR & TANKER				
OTHER				

ACCIDENT RECORD FOR THE PAST 3 YEARS				
Attach additional sheet if more space is needed. Check this box if none ☐				
DATES (List most recent first)	NATURE OF ACCIDENT (Head-on, rear-end, upset, etc.)	# FATALITIES	# INJURIES	CHEMICAL SPILLS (Y/N)

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)			
Attach additional sheet if more space is needed. Check this box if none ☐			
DATE CONVICTED (Month/Year)	VIOLATION	STATE OF VIOLATION	PENALTY (Forfeited bond, collateral and/or points)

Have you ever been denied a license, permit, or privilege to operate a motor vehicle? ☐ YES ☐ NO

If yes, explain

Has any license, permit, or privilege ever been suspended or revoked? ☐ YES ☐ NO

If yes, explain

EMPLOYMENT HISTORY

The Federal Motor Carrier Safety Regulations (49 CFR 391.21) require that all applicants wishing to drive a commercial vehicle list all employment for the last three (3) years. ***In addition, if you have driven a commercial vehicle previously, you must provide employment history for an additional seven (7) years (for a total of ten (10) years). Any gaps in employment in excess of one (1) month must be explained.***

Start with the last or current position, including any military experience, and work backwards (attach separate sheets if necessary). You are required to list the complete mailing address, including street number, city, state, zip; and complete all other information.

CURRENT (MOST RECENT) EMPLOYER					
NAME		PHONE			
ADDRESS					
POSITION HELD		FROM MO/YR		TO MO/YR	
REASON FOR LEAVING				SALARY	
EXPLAIN ANY GAPS IN EMPLOYMENT (Include month/year & reason)					

While employed here, were you subject to the Federal Motor Carrier Safety Regulations?	☐ Yes	☐ No
Was the job designated as a safety sensitive function in any Department of Transportation-regulated mode subject to alcohol and controlled substances testing as required by 49 CFR, part 40.	☐ Yes	☐ No

SECOND (MOST RECENT) EMPLOYER					
NAME		PHONE			
ADDRESS					
POSITION HELD		FROM MO/YR		TO MO/YR	
REASON FOR LEAVING				SALARY	
EXPLAIN ANY GAPS IN EMPLOYMENT (Include month/year & reason)					

While employed here, were you subject to the Federal Motor Carrier Safety Regulations?	☐ YES	☐ NO
Was the job designated as a safety-sensitive function in any Department of Transportation-regulated mode subject to alcohol and controlled substances testing as required by 49 CFR, part 40?	☐ YES	☐ NO

THIRD (MOST RECENT) EMPLOYER					
NAME		PHONE			
ADDRESS					
POSITION HELD		FROM MO/YR		TO MO/YR	
REASON FOR LEAVING				SALARY	
EXPLAIN ANY GAPS IN EMPLOYMENT (Include month/year & reason)					

While employed here, were you subject to the Federal Motor Carrier Safety Regulations? ☐ YES ☐ NO

Was the job designated as a safety-sensitive function in any Department of Transportation-regulated mode subject to alcohol and controlled substances testing as required by 49 CFR, part 40? ☐ YES ☐ NO

EDUCATION						
SCHOOL	NAME & LOCATION	COURSE OF STUDY	YEARS COMPLETED	GRADUATE Y	GRADUATE N	DETAILS
High School				☐	☐	
College				☐	☐	
Other				☐	☐	

OTHER QUALIFICATIONS
Please list any other qualifications that you have and which you believe should be considered.

TO BE READ AND SIGNED BY APPLICANT
I authorize you to make investigations (including contacting current and prior employers) into my personal, employment, financial, medical history, and other related matters as may be necessary in arriving at an employment decision. I hereby release employers, schools, health care providers, and other persons from all liability 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 interview(s) may result in discharge. I also understand that I am required to abide by all rules and regulations of the Company. I understand that the information I provide regarding my current and/or prior 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. I understand that I have the right to: • Review information provided by current/previous employers; • Have errors in the information corrected by previous employers, and for those previous employers to resend the corrected information to the prospective employer; and • 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. This certifies that I completed this application, and that all entries on it and information in it are true and complete to the best of my knowledge. Note: A motor carrier may require an applicant to provide more information than that required by the Federal Motor Carrier Safety Regulations.

Applicant Signature		Date	
Applicant Name (printed)			

EEO-1 Voluntary Self Identification Form

The Equal Employment Opportunity Commission (EEOC) requires all private employers with 100 or more employees as well as federal contractors and first-tier subcontractors with 50 or more employees AND contracts of at least $50,000 complete an EEO-1 report each year. Covered employers must invite employees to self-identify gender and race for this report.

Completion of this form is voluntary and will not affect your opportunity for employment, or the terms or conditions of your employment. This form will be used for EEO-1 reporting purposes only and will be kept separate from all other personnel records only accessed by the Human Resources department. Please return completed forms to the HR department.

If you choose not to self-identify your race/ethnicity at this time, the federal government requires [Company Name] to determine this information by visual survey and/or other available information.

NAME: _____

JOB TITLE: _____

DATE COMPLETED: _____

GENDER:
(Please check one of the options below)

_____ Male

_____ Female

RACE/ETHNICITY:
(Please check one of the descriptions below corresponding to the ethnic group with which you identify.)

___ Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

___ White (Not Hispanic or Latino): A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

___ Black or African American (Not Hispanic or Latino): A person having origins in any of the black racial groups of Africa.

___ Native Hawaiian or Pacific Islander (Not Hispanic or Latino): A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.

___ Asian (Not Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

___ Native American or Alaska Native (Not Hispanic or Latino): A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

___ Two or more races (Not Hispanic or Latino): All persons who identify with more than one of the above five races.

___ I do not wish to disclose.

Voluntary Self-Identification of Disability

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OMB Control Number 1250-0005
Expires 05/31/2023

Name: _____ Date: _____

Employee ID: _____
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability

☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability

☐ I Don't Wish To Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____