DriveAxleApp.com

19 pages

including this cover sheet

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Driver's Application For Employment

Print Form

Applicant Name Tracy Ziegler Date of Application 6-8-21

Company

Address 6519 W. Holiday St.

City Homosassa State FL Zip Code 34446

In compliance with Federal and State equal employment opportunities laws, qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital status, veteran status, non-job related disability, or any other protected group status.

TO BE READ AND SIGNED BY APPLICANT

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, inquiries 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 personal 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 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:

* Review information provided by previous employers;

* Have errors in the information corrected by previouse employers and for those previouse employers to re-send 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.

Signature Tracy Ziegler Date 6-8-21

FOR COMPANY USE

PROCESS RECORD

APPLICANT HIRED _____ REJECTED _____

DATE EMPLOYED _____ POINT EMPLOYED _____

DEPARTMENT _____ CLASSIFICATION _____

(IF REJECTED SUMMARY REPORT OF REASONS SHOULD BE PLACED IN FILE)

SIGNATURE OF INTERVIEWING AGENT _____

TERMINATION OF EMPLOYMENT

DATE TERMINATED _____ DEPARTMENT RELEASED FROM _____

DISMISSED _____ VOLUNTARILY QUIT _____ OTHER _____

TERMINATION REPORT PLACED IN FILE _____ SUPERVISOR _____

APPLICANT TO COMPLETE

(answer all questions - please print)

Position(s) Applied for: Driver

Last Name: Ziegler First Name: Tracy Middle: Lee SSN: 329-62-0673

List your addresses for the past 3 years.

Current Address: Address 6519 W. Holiday st City Homosassa State FL Zip 34446 Phone _____ How Long? 20yr.

Previous Addresses:

Address N/A City _____ State _____ Zip _____ How Long? _____

Address N/A City _____ State _____ Zip _____ How Long? _____

Address N/A City _____ State _____ Zip _____ How Long? _____

Address N/A City _____ State _____ Zip _____ How Long? _____

Do you have the legal right to work in the United States? (✓) Yes ( ) No

Date of Birth: 10-5-1973 (Required for Commercial Drivers) Can you provide proof of age? (✓) Yes ( ) No

Have you worked for this company before? ( ) Yes (✓) No Where? N/A

Dates: From N/A To N/A Rate of Pay $50 Position Driver

Reason for leaving _____

Are you now employed? ( ) Yes (✓) No If not, how long since leaving last employment? _____

Who referred you? Craiglist Rate of pay expected $50

Have you ever been bonded? ( ) Yes (✓) No Name of bonding company _____

(Answer only if a job requirement)

Have you ever been convicted of a felony? ( ) Yes (✓) No If yes, please explain fully on a separate sheet of paper. Conviction of a crime is not an automatic bar to employment-all circumstances will be considered.

Is there any reason you might be unable to perform the functions of the job for which you have applied [as described in the attached job description]? ( ) Yes ( ) No

If yes, explain if you wish

none

EMPLOYMENT HISTORY

All driver applicants to drive in interstate commerce must provide the following information on all employers during the preceding 3 years. List complete mailing address, street number, city, state and zip code.

Applicants to drive a commercial motor vehicle in interstate or intrastate commerce shall also provide an additional 7 years' information on those employers for whom the applicant operated such vehicle. (NOTE: List employers in reverse order starting with the most recent. Add another sheet as necessary.)

EMPLOYER	DATE
Name _____	From _____ To _____
Address _____	
City _____ State _____ Zip _____	Position Held _____
Contact Person _____ Phone Number _____	Salary/Wage _____
Were you subject to the FMCSRs while employed? ( ) Yes ( ) No	Reason for Leaving _____

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? ( ) Yes ( ) No

Truck Driver App.

APPLICATION FOR EMPLOYMENT

COMPANY _____ STREET ADDRESS _____

CITY, STATE AND ZIP CODE _____

NAME Tracy Lee Ziegler (First) (Middle) (Maiden Name, if any) (Last)

ADDRESS 6519 W. Holiday St. Homosassa, FL 34446 (Street) (City) (State) (Zip) HOW LONG? 20yr.

DATE OF BIRTH 10-5-1973 SOCIAL SEC. NO. 329-62-0673

ADDRESS none HOW LONG? _____
(Street) (City) (State) (Zip)

FOR PAST THREE YEARS

(Street) none (City) (State) (Zip) HOW LONG? _____

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS—DRIVER

	STATE	LICENSE NO.	TYPE	EXPIRATION DATE
DRIVER	FL	Z246817733650	A	10-5-72
LICENSES				

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	(VAN, TANK, FLAT, ETC.)	FROM	TO	(TOTAL) NO. OF MILES
STRAIGHT TRUCK	I Been driving		Since	2001
TRACTOR—SEMI-TRAILER				
TRACTOR—TWO TRAILERS	grown up on		farm	
OTHER				

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED)

	DATES	(HEAD-ON, REAR-END, UPSET, ETC.)	FATALITIES	INJURIES
LAST ACCIDENT	June 3 2018	Hit by Rick Truck	no	no
NEXT PREVIOUS	Was not on my	Ticketed not DOT as just	at fault crash	

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

LOCATION	DATE	CHARGE	PENALTY
Marion County, TX	6-7-2016	Red light	Camera

(ATTACH SHEET IF MORE SPACE IS NEEDED)

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES ______ NO ✓

B. Has any license, permit or privilege ever been suspended or revoked? YES ______ NO ✓

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

EMPLOYMENT RECORD (Attach Sheet if More Space is Needed)

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

LAST EMPLOYER: NAME ______

ADDRESS ______

POSITION HELD ______ FROM ______ TO ______ SALARY ______

REASONS FOR LEAVING ______

SECOND LAST EMPLOYER: NAME ______

ADDRESS ______

POSITION HELD ______ FROM ______ TO ______ SALARY ______

REASONS FOR LEAVING ______

THIRD LAST EMPLOYER: NAME ______

ADDRESS ______

POSITION HELD ______ FROM ______ TO ______ SALARY ______

REASONS FOR LEAVING ______

TO BE READ AND SIGNED BY APPLICANT

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

6-8-2021
Date

[signature]
Applicant's Signature

[illegible]

All driver applicants to drive in interstate commerce must provide the following information on all employers during the preceding three years. List complete mailing address, street number, city, state, and zip code.

Applicants to drive a commercial motor vehicle* in interstate or intrastate commerce shall also provide an additional seven years information on those employers for whom the applicant operated such vehicle.

(NOTE: List employers in reverse order starting with the most recent. Add another sheet as necessary.)

EMPLOYER	DATE
NAME: Bard Transport	FROM MO. 2 YR. 21 TO MO. 6 YR. 21
ADDRESS: 4445 Forest ave	POSITION HELD: Driver
CITY: Brookfield STATE: IL ZIP: 6513	SALARY/WAGE: .68
CONTACT PERSON: Saftey PHONE #: ( )	REASON FOR LEAVING: Retention pay
EMPLOYER	**DATE**
NAME: MTC Friegnt	FROM MO. [illegible] YR. 2019 TO MO. Dec YR. 20
ADDRESS: 11773 8th ave	POSITION HELD: Driver
CITY: Saint Petersburg STATE: FL ZIP:	SALARY/WAGE: .60
CONTACT PERSON: Saftey PHONE #: (727) 2029293	REASON FOR LEAVING: Driver
EMPLOYER	**DATE**
NAME: South Trans	FROM MO. Feb YR. 19 TO MO. May YR. [illegible]
ADDRESS: 1453 embassy dr.	POSITION HELD:
CITY: Clearwater STATE: FL ZIP:	SALARY/WAGE: Could not speak English
CONTACT PERSON: Saftey PHONE #: ( )	REASON FOR LEAVING:
EMPLOYER	**DATE**
NAME: Ziegler World Wide	FROM MO. Dec YR. 2015 TO MO. Feb YR. 2019
ADDRESS: 6519 W. Holiday St.	POSITION HELD: my own
CITY: Homosassa STATE: FL ZIP: 34446	SALARY/WAGE: Authority
CONTACT PERSON: PHONE #: (352) 601-6047	REASON FOR LEAVING: Closed Buiss
EMPLOYER	**DATE**
NAME:	FROM MO. YR. TO MO. YR.
ADDRESS:	POSITION HELD:
CITY: STATE: ZIP:	SALARY/WAGE:
CONTACT PERSON: PHONE #: ( )	REASON FOR LEAVING:
EMPLOYER	**DATE**
NAME:	FROM MO. YR. TO MO. YR.
ADDRESS:	POSITION HELD:
CITY: STATE: ZIP:	SALARY/WAGE:
CONTACT PERSON: PHONE #: ( )	REASON FOR LEAVING:

* Includes vehicles having a 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.

Revised 12/06/2002

USE THIS SHEET FOR ADDITIONAL EMPLOYMENT HISTORY INFORMATION
(NOTE: LIST EMPLOYERS IN REVERSE ORDER STARTING WITH THE MOST RECENT)

[illegible] during the preceding 3 years. List complete mailing address, street number, city, state and zip code.

Applicants to drive a commercial motor vehicle in interstate commerce shall also provide an addi[illegible] years' information on those employers for whom the applicant operated such vehicle.
(NOTE: List employers in reverse order starting with the most recent.)

EMPLOYER — DATE
NAME DSC Express Transport — 9-15 to 12-15
ADDRESS [illegible] — Driver
CITY Ocala STATE FL ZIP — 40¢ mile
CONTACT PERSON Lynn — PHONE NUMBER 352-877-4142 Fleet Truck Maint.
[illegible]
[illegible]

EMPLOYER — DATE
NAME Peterson Trucking — 12-15 to 9-15
ADDRESS 3960 SW 1st Ave — Driver
CITY Ocala STATE FL ZIP 32607 — 40¢ mile
CONTACT PERSON Dr. Peterson — PHONE NUMBER 352-245-4874 Accident
[illegible]
WAS YOUR JOB DESIGNATED AS A SAFETY SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL [illegible]

EMPLOYER — DATE
NAME DSC Express Transport — 12-13 to 6-15
ADDRESS [illegible] — Driver
CITY Ocala STATE FL ZIP — 42¢ mile
CONTACT PERSON Lynn — PHONE NUMBER 352-[illegible] Fleet Maint.
[illegible]
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL [illegible]

EMPLOYER — DATE
NAME Reed Tires — 19 12-12-13
ADDRESS 30 Box 499/217 E Commerce St — Driver
CITY Cedar Grove STATE WI ZIP 53013 — 39¢ mile
[illegible]
WERE YOU SUBJECT TO THE FMCSR'S WHILE EMPLOYED? YES NO
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL [illegible]

EMPLOYER — DATE
NAME Jasna — [illegible]-13
ADDRESS 2344 Carson Dr — Driver
CITY Leesburg STATE FL ZIP 34748 — 32¢/mile
[illegible]
WERE YOU SUBJECT TO THE FMCSR'S WHILE EMPLOYED? YES NO
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL [illegible]

EMPLOYMENT HISTORY (continued)

EMPLOYER

NAME ABCO Transport

ADDRESS

CITY Dade City STATE FL ZIP

CONTACT PERSON Safety PHONE NUMBER

WERE YOU SUBJECT TO THE FMCSRs WHILE EMPLOYED? YES 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? YES NO

DATE

FROM MO 12 YR 12 TO MO 7 YR 13

Driver

SALARY/WAGE 38¢/mile

REASON FOR LEAVING Looking for Something

EMPLOYER

NAME Wilson Company

ADDRESS 4230 Pine Bend Trail

CITY Rosemount STATE MN ZIP

CONTACT PERSON PHONE NUMBER

WERE YOU SUBJECT TO THE FMCSRs WHILE EMPLOYED? YES 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? YES NO

DATE

FROM MO 4 YR 12 TO MO 11 YR 12

Driver

SALARY/WAGE 37¢/mile

REASON FOR LEAVING Did not Desire

EMPLOYER

NAME Lessors Inc.

ADDRESS 1056 Gemini Rd

CITY Logan STATE IOWA ZIP 51521

CONTACT PERSON Safety PHONE NUMBER 651-454-1202

WERE YOU SUBJECT TO THE FMCSRs WHILE EMPLOYED? YES 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? YES NO

DATE

FROM MO 8 YR 11 TO MO 4 YR 12

Driver

SALARY/WAGE

REASON FOR LEAVING No Miles

EMPLOYER

NAME Sunco Transport

ADDRESS 1025 N. Chestnut Rd

CITY Plant City STATE FL ZIP 33565

CONTACT PERSON Safety PHONE NUMBER 1-800-231-9288

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? YES NO

DATE

FROM MO 4 YR 11 TO MO 8 YR 11

Driver

SALARY/WAGE

REASON FOR LEAVING No Money

EMPLOYER

NAME Carter Transport

ADDRESS 124 Harden St.

CITY Mandan STATE ND ZIP 58554

CONTACT PERSON PHONE NUMBER 1-800-395-3000

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? YES NO

DATE

FROM MO 6 YR 10 TO MO 4 YR 11

Driver

SALARY/WAGE 37¢/mile

REASON FOR LEAVING No Miles

Includes vehicles having a Gross Vehicle Weight Rating (GVWR) or Gross Combination Weight Rating (GCWR) of 10,001 or more pounds, or any size vehicle that is used to transport hazardous materials in a quantity requiring placarding.

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) has a GVWR of 10,001 or more pounds; (2) is designed or used to transport more than 8 passengers (including the driver); OR (3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

EMPLOYMENT HISTORY (continued)

EMPLOYER	DATE
NAME Walton + Company	FROM MO 2 YR 9 TO MO 6 YR 10
ADDRESS 9231 Time Blvd III.	POSITION Driver
CITY Rosemont STATE MN ZIP	SALARY/WAGE 34 $/mile
CONTACT PERSON Safety PHONE NUMBER 651-304-2097	REASON FOR LEAVING Laid Off
WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? YES 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? YES NO	

EMPLOYER	DATE
NAME Ziegler's Lawn + Landscaping	FROM MO 6 YR 7 TO MO 2 YR 9
ADDRESS 3619 S. Victoria Dr	POSITION Labor/Driver
CITY Homosassa STATE FL ZIP 34446	SALARY/WAGE $520 Weekly
CONTACT PERSON Mike or Cindy PHONE NUMBER 352-628-5844	REASON FOR LEAVING Business Slowed
WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? YES 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? YES NO	

EMPLOYER	DATE
NAME Dicks Moving	FROM MO 9 YR 6 TO MO 6 YR 7
ADDRESS 4231 S. 3rd St.	POSITION Driver
CITY Homosassa STATE FL ZIP 34448	SALARY/WAGE Per Job
CONTACT PERSON Safety PHONE NUMBER 352-628-1220	REASON FOR LEAVING Laid Off
WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? YES 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? YES NO	

EMPLOYER	DATE
NAME Arnold + Sons	FROM MO 2 YR 5 TO MO 9 YR 6
ADDRESS 5430 W. Grover Cleveland	POSITION Driver
CITY Homosassa STATE FL ZIP 34446	SALARY/WAGE Per mile
CONTACT PERSON Dan 352-436-3432 PHONE NUMBER 352-586-3048	REASON FOR LEAVING Closed Business
WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? YES 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? YES NO	

EMPLOYER	DATE
NAME	FROM MO YR TO MO YR
ADDRESS	POSITION
CITY STATE ZIP	SALARY/WAGE
CONTACT PERSON PHONE NUMBER	REASON FOR LEAVING
WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? YES 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? YES NO	

*Includes vehicles having a GVWR of 26,001 lbs. or more, vehicles designed to transport 16 or more passengers (including the driver), or any size vehicle used to transport hazardous materials in a quantity requiring placarding.

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) has a GVWR of 10,001 pounds or more; (2) is designed or used to transport more than 8 passengers (including the driver) for compensation; (3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

Form MCSA-5875

OMB No. 2126-0006 Expiration Date:

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECOR

(or sticker)

SECTION 1. Driver Information (to be filled out by the driver)

PERSONAL INFORMATION

Last Name: Ziegler First Name: Tracy Middle Initial: L Date of Birth: 10/05/1973 A

Street Address: 6519 W. Holiday St City: Homosassa State/Province: FL Zip Code: 34

Driver's License Number: Z246-812-73-365-0 Issuing State/Province: FL Phone: (352) 601-6027 Gender: ⦿ M

E-mail (optional): ziegliertracy93@yahoo.com CLP/CDL Applicant/Holder*: ⦿ Yes ○ No

Driver ID Verified By**: License

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ⦿ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions

**Driver ID verified by: record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license,

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ⦿ Yes ○ No ○ Not

Left knee injury

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? If "yes," please describe below. ⦿ Yes ○ No ○ Not S

Metformin (unsure of dosage) BID

(Attach additional sheets if necessary)

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Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: Ziegler First Name: Tracy DOB: 10/05/1973 Exam Date: 11/05/2020

DRIVER HEALTH HISTORY (continued)

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses (e.g., concussion)	○	◉	○
2. Seizures, epilepsy	○	◉	○
3. Eye problems (except glasses or contacts)	○	◉	○
4. Ear and/or hearing problems	○	◉	○
5. Heart disease, heart attack, bypass, or other heart problems	○	◉	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	◉	○
7. High blood pressure	○	◉	○
8. High cholesterol	○	◉	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	◉	○
10. Lung disease (e.g., asthma)	○	◉	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	◉	○
12. Stomach, liver, or digestive problems	○	◉	○
13. Diabetes or blood sugar problems	◉	○	○
Insulin used	○	◉	○
14. Anxiety, depression, nervousness, other mental health problems	○	◉	○
15. Fainting or passing out	○	◉	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	◉	○
17. Unexplained weight loss	○	◉	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	◉	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	◉	○
20. Neck or back problems	○	◉	○
21. Bone, muscle, joint, or nerve problems	○	◉	○
22. Blood clots or bleeding problems	○	◉	○
23. Cancer	○	◉	○
24. Chronic (long-term) infection or other chronic diseases	○	◉	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	◉	○
26. Have you ever had a sleep test (e.g., sleep apnea)?	○	◉	○
27. Have you ever spent a night in the hospital?	○	◉	○
28. Have you ever had a broken bone?	○	◉	○
29. Have you ever used or do you now use tobacco?	◉	○	○
30. Do you currently drink alcohol?	○	◉	○
31. Have you used an illegal substance within the past two years?	○	◉	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	◉	○

Other health condition(s) not described above: ○ Yes ◉ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ◉ Yes ○ No ○ Not Sure

13. Takes medication as prescribed
29. Smokes about 1 pack of cigarettes a per day

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report (to be filled out by the medical examiner)

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

Left patellar fracture in childhood. No residual symptoms.
Takes medication as prescribed.

(Attach additional sheets if necessary)

Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: Ziegler First Name: Tracy DOB: 10/05/1973 Exam Date: 11/05/2020

TESTING

Pulse rate: 68 Pulse rhythm regular: (•) Yes ( ) No Height: 5 feet 8 inches Weight: 234 pounds

Blood Pressure	Systolic	Diastolic
Sitting	132	80
Second reading (optional)		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.010	Neg	Neg	2000+

Other testing if indicated

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected
Right Eye:	20/15	20/___
Left Eye:	20/20	20/___
Both Eyes:	20/20	20/___

Horizontal Field of Vision
Right Eye: 90 degrees
Left Eye: 90 degrees

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	(•)	( )
Monocular vision	( )	(•)
Referred to ophthalmologist or optometrist?	( )	(•)
Received documentation from ophthalmologist or optometrist?	( )	(•)

Hearing

Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☒ Neither

Whisper Test Results	Right Ear	Left Ear
Record distance (in feet) from driver at which a forced whispered voice can first be heard	5	5

OR

Audiometric Test Results

	Right Ear			Left Ear		
	500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz

Average (right): Average (left):

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	(•)	( )	8. Abdomen	(•)	( )
2. Skin	(•)	( )	9. Genito-urinary system including hernias	( )	(•)
3. Eyes	(•)	( )	10. Back/Spine	(•)	( )
4. Ears	(•)	( )	11. Extremities/joints	(•)	( )
5. Mouth/throat	(•)	( )	12. Neurological system including reflexes	(•)	( )
6. Cardiovascular	(•)	( )	13. Gait	(•)	( )
7. Lungs/chest	(•)	( )	14. Vascular system	(•)	( )

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

Request PCP documentation and clearance that NIDDM is being monitored and controlled due to glycosuria.
Recommend cessation.
Recommend continued diet and exercise.

(Attach additional sheets if necessary)

Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: Ziegler First Name: Tracy DOB: 10/05/1973 Exam Date: 11/05/2020

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- ○ Does not meet standards *(specify reason)*:
- ○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ⊙ Meets standards, but periodic monitoring required *(specify reason)*: NIDDM

Driver qualified for: ○ 3 months ○ 6 months ✓ 1 year ○ other *(specify)*:

- ☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*:
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)
- ☐ Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)
- ☒ Determination pending *(specify reason)*: Documentation of glucose monitoring.
  - ☒ Return to medical exam office for follow-up on (*must be 45 days or less*) 11/30/2020
  - ☒ Medical Examination Report amended *(specify reason)*:
  - *(if amended)* Medical Examiner's Signature: Date:
- ☐ Incomplete examination *(specify reason)*:

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification, I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge I believe it to be true and correct.

Medical Examiner's Signature:

Medical Examiner's Name *(please print or type)*: Geneva Stephens

Medical Examiner's Address: 2649 W. Silver Springs Blvd City: Ocala State: FL Zip Code: 34475

Medical Examiner's Telephone Number: (352)789-6777 Date Certificate Signed: 11/05/2020

Medical Examiner's State License, Certificate, or Registration Number: CH9961 Issuing State: FL

☐ MD ☐ DO ☐ Physician Assistant ☒ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*:

National Registry Number: 9456701840 Medical Examiner's Certificate Expiration Date: 11/5/202

Form MCSA-5876

OMB No. 2126-0006 Expiration Date: 11/30/2021

Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 1 minute per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments concerning the duration and content of any other aspect of this collection of information, including suggestions for reducing this burden, to Information Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, DC 20590.

Federal Motor Carrier Safety Administration

Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined Last Name: Ziegler First Name: Tyler in accordance with

☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and if applicable, only when [illegible]; OR

☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations) and, with knowledge of the driving duties, I find this person is qualified, and if applicable, only when [illegible]:

☐ Wearing corrective lenses ☐ Accompanied by a _____ waiver/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.62) [illegible]

☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 [illegible]

☐ Qualified under interim State requirements [illegible]

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date: 11/5/2021

Medical Examiner's Signature: [signature]

Medical Examiner's Telephone Number: 3527891611 **Date Certificate Signed:** 11/5/2020

Medical Examiner's Name (please print or type): Geneva Stephens

☐ MD ☐ DO ☒ Physician Assistant ☐ Advanced Practice Nurse

Medical Examiner's State License, Certificate, or Registration Number: CT19261 **Issuing State:** FL **National Registry Number:** 9456701840

Driver's Signature: [signature]

Driver's License Number: Z246812733650 **Issuing State/Province:** FL

Driver's Address

Street Address: 1519 W Holiday St Homosassa FL 34446 **CLP/CDL Applicant/Holder:** ☒ Yes ☐ No

** This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements. **

MVR RELEASE CONSENT FORM

In conjunction with my employment, at _____ ("the company"),

I Tracy Ziegler (print name) (employee/applicant name) Consent to the release of my Motor Vehicle Record (MVR) to the company. I understand the company will use these records to evaluate my suitability to fulfill driving duties that may be related to the position for which I am applying. I also consent to the review, evaluation, and other use of any MVR I may have provided to the company.

This consent is given in satisfaction of Public Law 18 USC 2721 et. Seq., "Federal Drivers Privacy Protection Act", and is intended to constitute "written consent" as required by this Act.

Tracy Ziegler
Employee/Applicant Signature

6-8-21
Date

10-5-1973
Date of Birth

0673
Social Security Number (last 4 digits)

Z246-812-73-365D
Drivers' License Number

License Expiration Date

FL.
Issuing State

(Required for all drivers)

Direct Deposit Authorization

I authorize _____ to send credit entries, as well as appropriate adjustments and debit entries, to my/our accounts as indicated below.

Account #1

Account Type: ✓ Checking ____ Savings

Institution Name: Suntrust

Bank Routing #/ ABA #: 061000104 Account#: 063102152

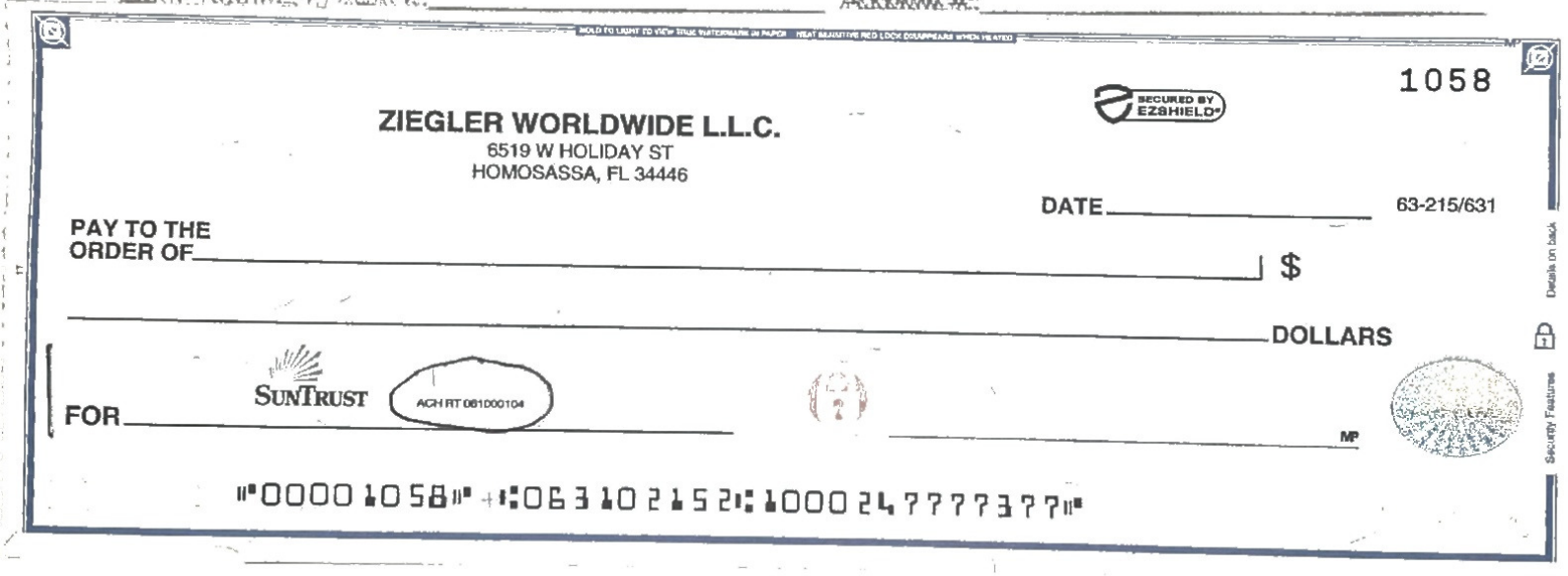
Percentage to be deposited into this account: 100%

Account #2

Account Type: ____ Checking ____ Savings

Institution Name: _____

Bank Routing #/ ABA #: _____ Account #: _____



Tracy Ziegler
Signature

6-8-21
Date

Tracy Ziegler
Printed Name

Ziegler WorldWide LLC

SampleWords

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** 1

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 . . . **F** ____

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

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

- If your total income will be less than $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** 1

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: Tracy L.	Last name: Ziegler	2 Your social security number: 329-62-0673
Home address (number and street or rural route): 6519 W. Holiday St.	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: Homosassa FL 34446	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.) ▶ Tracy Ziegler [signature] **Date** ▶ 6-8-21

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)

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)
Ziegler	Tracy	L.	None

Address (Street Number and Name)	Apt. Number	City or Town	State	ZIP Code
6579 W. Holiday St	N/A	Homosassa	FL	34446

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
10-05-1973	136-91-6173	Zieglertracy93@yahoo.com	352-601-6027

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):

- [x] 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)
Tracy Ziegler	06-08-2021

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

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

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
	Ziegler	Tracy B	L.	Citizen

List A	OR	List B	AND	List C
Identity and Employment Authorization		Identity		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