



DOT and FMCSA History Form

Previous Employee Investigation & Inquiries

Section 1: Previous employee information & release

Name: _____ SSN: _____

DOB: _____ Driver License # _____ State Issued: _____

I hereby authorize _____ to release the following requested information to DISA Global Solutions on behalf of prospective employer _____ for the purpose of investigation to qualify me to drive a commercial motor vehicle as required by the U.S. Department of Transportation & Federal Motor Carrier Safety Administration regulations 49 CFR Part 40.25 and 391.23. As the Applicant named above, I hereby authorize the previous employer listed below to release information from my Department of Transportation regulated drug and alcohol testing records and safety performance history in accordance with 49 CFR Part 40.25 and 391.23.

Driver Signature: _____ Date: _____

SECTION 2: NOTE REGULATIONS OF THE DEPARTMENT OF TRANSPORTATION (49 CFR part 40)

Requires your company to provide us with information concerning named driver's past drug and alcohol test results including refusals to be tested.

In the past three years has the previously named applicant ever:

Tested positive for a controlled substance? Yes No

Tested with a n alcohol concentration of 0.04 or higher? Yes No

Refused to submit to a DOT drug or alcohol test including a verified adulterated or substituted result? Yes No

Had any other violations of DOT drug/alcohol testing requirements? Yes No

Had any other violations of drug /alcohol regulations from previous employers? Yes No

NOTE: If you answered 'yes' to any of the above items, did the employee complete the return-to-duty process? N/A Yes No

• Did the above named individual drive a commercial motor vehicle (CMV) for you? Yes No

• Please provide the dates employed: _____ to _____

• Reason for leaving your company:
 Discharged Resignation Layoff Military Duty Other (specify): _____

• While a CMV driver for you, was the individual involved in any accidents as defined in 390.5? Yes No

If yes, please supply the following information for any accident on your accident register (390.15(b)) that involved the above named individual for the three (3) years prior to the date next to their signature.

Date	Location	# of Injuries	# of Fatalities	Hazmat Spill?	
1.				<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.				<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.				<input type="checkbox"/> Yes	<input type="checkbox"/> No

(If you marked yes please provide the SAP contact Information):

NAME OF SAP SPECIALIST _____ PHONE _____

ADDRESS EMAIL _____

Your Name (Print): _____ Title: _____

Your Signature: _____ Date: _____

For more information call us:
714-731-3084

Return via fax to:
800-787-8179

or by email to:
Tustin.docman@disa.com