SECURE PATIENT DELIVERY, LLC
EMPLOYMENT APPLICATION

Date:_____

Name:_____ SS Number:_____-_____-_____
(Last) (First) (Middle)

Address:_____
(Street) (City) (State) (Zip Code)

Mailing Address if different than the above **(please make sure that all info is correct)**:

_____
(Street) (City) (State) (Zip Code)

Phone #1_____ Phone#2:_____

Email address:_____

Date of Birth: _____ Are you legally eligible to work in the United States?_____
Do you have a valid Driver's License?_____
Do you have any accidents or moving violations within the past two years? How many?_____

EDUCATION: School Name **Years Attended** **Degree or Diploma**

High School:_____

College: _____

Trade School/Other: _____

Shift preferred: **No preference** **Day** **Night** **Will work either but prefer** DAY / NIGHT

Do you have reliable transportation: Yes No

Employment History: Please list all previous job information below:

Employer	**Employment Dates**	**Job Title**	**Hourly Pay Rate**

How did you hear about job opening: _____

My signature at the bottom of this page will verify that all information provided in this employment application is truthful and accurate. I understand that falsification of any part of this application may result in disciplinary action, which may include employment termination.

Included with this application, there is a document entitled "Employee Health Care Reform Notice." I acknowledge, with my signature at the bottom of this page, receiving this document. It is my responsibility to read this notice in its entirety and refer to resources located within the document for any further information.

Signature Required_____ **Date** _____

Attachment II

TO: All SPD Employees

FROM: Sal Monfra, Vice-President of Operations

SUBJECT: Drug Free Workplace Program

Secure Patient Delivery, LLC (SPD) maintains a Drug Free Workplace Program. Employees are prohibited from using illegal drugs (including the non-prescribed use of prescription medication) on or off the employer's premises or anytime the employee is on active duty. Employees are also prohibited from possessing or transporting alcohol or illegal drugs on the premises or when on active duty. Possession of paraphernalia used in connection with the use of any drug is evidence of violation of this rule. Drugs mean alcohol, including distilled spirits, wine, malt beverages and intoxicating liquors, amphetamines, cannabinoids, cocaine, phencyclidine (PCP), hallucinogens, methaqualone, opiates, barbiturates, benzodiazepines, synthetic narcotics, designer drugs or metabolite of any of these substances. Non-prescribed use of prescription medication is also prohibited. SPD requires all applicants for employment and all existing employees, under certain circumstances, to be tested for the presence of drugs or alcohol as part of the SPD policy prohibiting drug or alcohol use. An employee violates the Drug Free Workplace Program by testing positive in a confirmed test for drugs or alcohol. Refusal to cooperate in the drug testing procedure is an independent violation of this rule and accordingly, will be treated as a positive confirmed test for drugs or alcohol. Upon conviction for violating any state or federal drug law, every SPD employee is required to notify his or her immediate supervisor of such conviction within five business days thereof. This "notification of drug conviction" requirement applies whether the conviction resulted from conduct performed while in the course and scope of employment or off duty. Employees are required to report any drug related criminal charge brought against them, whether the result of on-duty or off-duty conduct.
SPD recognizes that drug and alcohol abuse is an on-the-job problem as well as a social problem. We believe that abuse of alcohol and the use of illegal drugs endangers the health and safety of the abusers and of others around them. SPD has committed to creating and maintaining a Drug Free Workplace without jeopardizing the job security of valued but troubled employees, provided they are prepared to help us help them.

All employees are made aware of the SPD commitment to a Drug Free Workplace during new employee orientation. Additionally, notice has been posted in a conspicuous location identifying SPD as a Drug Free Workplace. Copies of the SPD Drug Free Workplace policy are provided during orientation and are available for inspection at the SPD offices. Our Drug Free Workplace Policy formally states that substance abuse will not be tolerated ON or OFF the job for employees of our company. This prohibition includes the possession, use or sale of illegal drugs, the abuse of alcohol and abuse of prescribed drugs. All employees are expected to sign a statement of understanding and agreement with the company's Drug Free Workplace Policy. To ensure that SPD remains a Drug Free Workplace, a program of drug testing is in effect. Employees are subject to drug testing: 1) Pre-Employment, 2) Annual, 3) Post-Accident, 4) Reasonable Suspicion, 5) Random and 6) Return to Duty. Let it be clearly understood that it is a condition of employment for everyone that they avoid entirely the use, possession, sale or any association whatsoever with illegal drugs and/or the abuse of alcohol.

Employees who are found on the job to be under the influence of illegal drugs or alcohol or who violate this policy in other ways will be terminated. It is important that SPD employees work together to deal with substance abuse to make our company a safer and more rewarding place to work.

The testing parameters, including screening levels and confirmation levels, are detailed in the tables below.

DRUGS	SCREEN LEVEL	CONFIRM LEVEL
Amphetamines/Methamphetamines Ecstasy – MDMA, MDA, MDEA	300 (ng/ml)	250 (ng/ml)
Barbiturates	300 (ng/ml)	100 (ng/ml)
Benzodiazepines	300 (ng/ml)	100 (ng/ml)
Cocaine	150 (ng/ml)	100 (ng/ml)
Methadone	300 (ng/ml)	100 (ng/ml)
Opiates 6-Acetylmorphine (6-AM)	2000 (ng/ml) 10 ng/ml	2000 (ng/ml) Morphine 2000 (ng/ml) Codeine 10 (ng/ml) Heroin
Cannabinoids	20 (ng/ml)	10 (ng/ml)
PCP	25 (ng/ml)	25 (ng/ml)
Propoxyphene	300 (ng/ml)	200 (ng/ml)
Methaqualone	300 (ng/ml)	200 (ng/ml)
Alcohol	0.02% (BAC)	0.04% (BAC)
NOTE: Alcohol screening and confirmation methods are conducted according to DOT protocol. Substances and levels may be modified when applicable.		

Alcohol Cut-Off Levels		
TEST	SCREEN	CONFIRM (EBT)
DCC Alcohol	.02	.04 (.02 - .039)*
*Employee must be removed from duty until their next shift or until they test negative		
Employee is prohibited from duty if: ❖Test result is greater than .039 ❖Use alcohol on the job ❖Refuse to submit to alcohol test		

Employees that are under a physician's care and are required to take prescription medication must notify their supervisor in writing of that fact prior to reporting for duty the first day after the prescription was issued. No employee will be allowed to take medication while working if it may adversely affect his/her safety or the safety of other employees.

By signing this document, you agree to participate in the program and it is believed that this effort will assist in eliminating accidents and injury. Your cooperation in adhering to this policy will provide you and our customers with a better and safer working environment.

Sincerely,

Sal Monfra, Jr.
Vice-President of Operations

I have read and understand the above policy:

Printed Name Employees Signature Date

CONFIDENTIAL

Background Check Authorization

Print Name: _____

(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: _____

(Mo/Yr) (Street) (City) (Zip/State)

If less than five years -
Previous Address From: _____

(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____

(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: _____ DOB: _____

Telephone Number: _____

Drivers License Number/State: _____

The information contained in this application is correct to the best of my knowledge.

I hereby authorize Secure Patient Delivery, LLC and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Secure Patient Delivery, LLC or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Secure Patient Delivery, LLC and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

I also am aware that records of arrests on pending charges and/or convictions ***ARE NOT*** an absolute bar to employment or continued employment.

Signature: _____ Date: _____

MVR RELEASE CONSENT FORM

In conjunction with my potential employment at Secure Patient Delivery, LLC/Secure Patient Delivery Shuttle, LLC (SPD/SPDS), I, _____ consent to the release of my Motor Vehicle Records (MVR) to the SPD/SPDS. 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 SPD/SPDS. This consent is given in willingly and is intended to constitute "written consent" as required by law (US Code, Title 18, #2721 through #2725 and Section 350 of Public Law 106-69 which amended the Federal Driver Privacy Protection Act OLA File No. 1999-1126). By signing below, I authorize SPD/SPDS to obtain information relating to my driving record.

Signed_____Date_____

Name:_____

Address:_____

Date of Birth:_____

Drivers' License Number _____State: _____Class:_____

Expiration:_____

NOTICE TO ALL APPLICANTS AND EMPLOYEES

Secure Patient Delivery, LLC (SPD) has in effect a drug testing policy. As part of pre-employment procedures and, if hired, during your employment with SPD a drug screen may be requested under that policy. Under the Fair Credit Reporting Act, the drug screen may be considered a consumer report or an investigative consumer report and may include information about your general reputation, character, personal characteristics and/or mode of living. This is your notice of the right to request information regarding the drug screen report and it is also your agreement to abide by the drug testing policy of SPD. Your signature below signifies your receipt of the above information, your receipt of a copy of this document, and your permission to release the results of any drug screen to SPD and/or any SPD designee, including but not limited to the SPD Medical Review Officer (MRO), and any Client upon written request. You also agree that your refusal to submit to a drug screen may result in your failure to be hired, or if hired, your termination.

❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋❋

CONSENT

I have read the above disclosure and agree to undergo a drug screen any time at the request of SPD. I understand that refusal to submit to a drug screen may result in failure to be hired, or if hired, my termination. Further, I authorize SPD to request, receive and release the drug report as above described. Should the drug report constitute an investigative consumer report, I understand I have the right to receive additional information about the nature and scope of this investigative consumer report that is obtained and a summary of rights under the Fair Credit Reporting Act.

Name	Signature	Date

LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.[1] This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

Employee Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____

Employer Name: _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

[1] Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystropy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertension	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

☐ ☐ Spinal Disc Surgery Year (approximate if unsure)_____

☐ ☐ Spinal Fusion Surgery Year (approximate if unsure)_____

☐ ☐ Amputated Foot Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Leg Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Arm Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Hand Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Knee Replacement Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Hip Replacement Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Other Joint Replacement Joint _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

Employee Signature:_____ Date: _____

Employer Representative: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) **or** any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: ____ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ____

CONDITION: ____ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ____

CONDITION: ____ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ____

CONDITION: ____ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ____

Employee Signature: ________________________________ Date: ____________________

Employer Representative: ____________________________ Date: ____________________

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐
   If "Yes," please list the restrictions: _____
   Were the restrictions: Permanent ____ Temporary ____
   Are your activities currently restricted? Yes ☐ No ☐
   What is the medical condition for which you have restrictions? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

   Please list the medical condition being treated: _____

   Doctor's Name: _____Specialty: _____

   Doctor's Address: _____

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

   Medication: _____Prescribing Doctor: _____

   Medication: _____Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐
   If you answered "YES," please provide the date for each injury and the nature of the injury:

   _____

   How long were you on compensation? _____

   Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐
   If you answered YES, please provide:

   Recommended surgery: _____

   Approximate date of recommendation: _____

   Doctor's Name: _____Specialty: _____

   Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature:_____ Date: _____

Employee Printed Name: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;

2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;

3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;

4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and

5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq*., or any other state or federal law;

6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature:_____ Date: _____

Employer Representative Printed Name: _____

Title: _____

Secure Patient Delivery

EMPLOYMENT VERIFICATION REQUEST FORM

I, _____would like to request that the company provide the following documentation to confirm my employment status to the specified institution.

Agency/Company requesting information:
Secure Patient Delivery, LLC
2439 Manhattan Blvd, Suite 207
Harvey, LA 70058
Fax: (504) 304-6423
Email: _____

Type of documentation requested:

☐ Salary History - Hourly Rate:_____ Monthly Salary_____

☐ Confirmation of Employment Dates - Employed from:_____ until _____

☐ Rehire eligibility - Elgible For Rehire Yes / No

Any request for information must include the employee's signature. If a request is received with no signature indicating that the employee authorized the request, then this form must not, under any circumstances, be completed.

I hereby authorize Secure Patient Delivery, LLC to obtain my employment history, limited to the information detailed above, from _____. Additionally, I hereby authorize _____ to release my employment history, limited to the information detailed above.

_____
Employee Name

_____
Employee Signature

_____
Date