

MAGNESS OIL COMPANY

Driver Application

Motor Carrier Name: **MAGNESS OIL COMPANY**

Address: 167 TUCKER CEMETERY ROAD GASSVILLE, AR 72635

Applicant Instructions: If the answer to a question is "no", "none", or "N/A", please fill in the blank accordingly. Do not leave any questions blank.

Company Driver Contract Driver Date: _____

Name _____
First Middle Last

Home Phone _____ Date of Birth _____

Emergency Phone _____ Social Security Number _____

Current Address and 3 years Previous Addresses:

_____	_____	_____	_____	From _____	To _____
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Mo/Yr</i>	<i>Mo/Yr</i>
_____	_____	_____	_____	From _____	To _____
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Mo/Yr</i>	<i>Mo/Yr</i>
_____	_____	_____	_____	From _____	To _____
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Mo/Yr</i>	<i>Mo/Yr</i>
_____	_____	_____	_____	From _____	To _____
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Mo/Yr</i>	<i>Mo/Yr</i>

Education and Employment History:

Circle the highest grade completed: Grade School: 1 2 3 4 5 6 7 8 9 10 11 12
College: 1 2 3 4 Post Graduate: 1 2 3 4

Give a complete record of all employment including any unemployment or self-employment for the past 3 years, and all commercial driving experience for the past 10 years.

Present or Last Employer:

Name _____

Address _____ From _____ To _____
Street City State Zip Code Mo/Yr Mo/Yr

Position Held _____ Supervisor _____ Phone _____

Reason for Leaving _____

Were you subject to the FMCSR's while employed with this company? Yes No (circle one)
Was your position considered a safety-sensitive function in any DOT-regulated mode subject to controlled substance and alcohol testing requirements? Yes No (circle one)

Next Previous Employer:

Name _____

Address _____ From _____ To _____
Street City State Zip Code Mo/Yr Mo/Yr

Position Held _____ Supervisor _____ Phone _____

Reason for Leaving _____

Were you subject to the FMCSR's while employed with this company? Yes No (circle one)
Was your position considered a safety-sensitive function in any DOT-regulated mode subject to controlled substance and alcohol testing requirements? Yes No (circle one)

Next Previous Employer:

Name _____

Address _____ From _____ To _____
Street City State Zip Code Mo/Yr Mo/Yr

Position Held _____ Supervisor _____ Phone _____

Reason for Leaving _____

Were you subject to the FMCSR's while employed with this company? Yes No (circle one)
Was your position considered a safety-sensitive function in any DOT-regulated mode subject to controlled substance and alcohol testing requirements? Yes No (circle one)

Next Previous Employer:

Name _____

Address _____ From _____ To _____
Street City State Zip Code Mo/Yr Mo/Yr

Position Held _____ Supervisor _____ Phone _____

Reason for Leaving _____

Were you subject to the FMCSR's while employed with this company? Yes No (circle one)
Was your position considered a safety-sensitive function in any DOT-regulated mode subject to controlled substance and alcohol testing requirements? Yes No (circle one)

Next Previous Employer:

Name _____

Address _____ From _____ To _____
Street City State Zip Code Mo/Yr Mo/Yr

Position Held _____ Supervisor _____ Phone _____

Reason for Leaving _____

Were you subject to the FMCSR's while employed with this company? Yes No (circle one)
Was your position considered a safety-sensitive function in any DOT-regulated mode subject to controlled substance and alcohol testing requirements? Yes No (circle one)

Driving Experience

Equipment Class	Dates		Approximate Total Number of Miles
	From	To	
Straight Truck			
Tractor and Semi-Trailer			
Tractor – Doubles/Triples			
Other – Tanker, Flatbed, Specialized, etc.			

List states operated in for the past 5 years: _____

List special courses and/or training completed (HazMat, PTD/DDC, etc.): _____

List any Safe Driving Awards you earned and from whom: _____

Accident Record for the past 3 years

Date of Accident	Nature of Accidents (rear-end, lane change, upset, etc.)	Location of Accident	# of Fatalities	# of People Injured

Traffic Convictions and Forfeitures for the past 3 years (do not include parking violations)

Date	Location	Charge	Penalty

Driver's License (list each driver's license held in the past 3 years)

State	License #	Type	Endorsements	Expiration Date

Have you ever been denied a license, permit, or privilege to operate a motor vehicle? Yes / No

Has any license, permit, or privilege ever been suspended or revoked? Yes / No

Have you ever tested positive or refused a DOT controlled substance (drug) or alcohol pre-employment test within the past two years from an employer who did not hire you? Yes / No

Have you ever been convicted of a felony? Yes / No

If the answer to any of the above is "Yes", give details: _____

Confidential Faxed Safety Performance History to Past Employer

To: _____
Former or Current Employer _____ Date _____

Street Address _____ City, State, Zip Code _____

I understand that in accordance with 49 CFR, Part 391.21, the following information will be requested from all previous employers for which I have operated a commercial motor vehicle as defined in 49 CFR, Parts 40, 382, 383 and 390 for the past three years from the date above. I also acknowledge that this information will be used in determining my eligibility to be hired, that I have the right to review this information and the right to have errors corrected by my previous employers and the right to have a rebuttal statement attached to the alleged erroneous information in accordance with 49 CFR, Part 391.23(i).

I hereby authorize this company to release all records of employment, including assessments of my job performance, ability and fitness, including dates of any and all alcohol or drug tests, those confirmed results, and/or my refusal to submit to any alcohol or drug tests and any rehabilitation completion under direction of an SAP/MRO to each and every company or their agents which may request such information in connection with my application with said company. I hereby release this company and its employees, officers, directors and agents from any and all liability of any type as a result of providing the following information to the below mentioned person and/or company.

_____	_____
Applicant's Name (print)	Witness' Name (print)
_____	_____
Applicant's Signature	Witness' Signature

Personnel Manager or Director of Safety:

The person named herein has applied to this company for employment in a safety-sensitive position as defined by the FMCSR. Your firm is listed by the applicant as a past employer. Please reply to this inquiry respecting this driver applicant. As you will note from the waiver stated above, all liability of you and your company has been released by the applicant. You may reply by FAX to the number listed below.

From: _____ Title: _____
Company: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____
Applicant Name: _____ SS #: _____
Position Applying for: _____

Request for General Information:

Did the applicant work for you as a _____ from _____ to _____ ?
 Yes / No If "No", please explain: _____

If employed as a driver, please answer the following questions:

Circle one: Company Driver Owner Operator Other _____

Type of tractor operated: _____ Type of trailer pulled: _____

Other equipment operated: _____ Commodities transported: _____

General area of operation: _____

Traffic Violations: Yes / No If "yes", please note: _____

License suspensions: Yes / No If "yes", please note: _____

Reason employee left your company: _____

Would you rehire employee? Yes / No If "no", please explain: _____

Request for Alcohol and Controlled Substance Information for Preceding 3 years:

Alcohol tests with a result of 0.04 or greater: Yes / No If "yes", give date(s) _____

Verified positive controlled substances test results: Yes / No If "yes", give date(s) _____

Refusals to test: Yes / No If "yes", give date(s) _____

Rehab completed under direction of an SAP/MRO: Yes / No If "yes", give date(s) _____

Request for Accident Information for Preceding 3 years:

Was the applicant involved in any accidents as defined in Section 390.5? Yes / No

If "Yes", please fill out the information below as defined in Section 390.15.

Accident Date	City and State of Accident	Towed Vehicles? Y/N	Number of Injuries	Number of Fatalities	Hazardous Materials Spill Y/N

Additional Comments: (any problems with customer relations, supervision, equipment abuse, etc.) _____

 Motor Carrier Representative Name (please print)

 Title

 Motor Carrier Representative Signature

 Date

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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):

- A citizen or national of the United States
- A lawful permanent resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #)

Employee's Signature	Date (month/day/year)
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Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____	Document #: _____	Expiration Date (if any): _____
I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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		Date (month/day/year)

Form W-4 (2009)

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 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not 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-earner/multiple job 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 for details.

Nonresident alien. If you are a nonresident alien, see the instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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: **B** _____

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

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 \$1,800 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. **G** _____

- If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
- If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children.

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. **(Note. This may be different from the number of exemptions you claim on your tax return.)**

- 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 have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 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.

Cut 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	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="font-size: small; margin: 0;">▶ 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.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; margin: 5px 0;">2009</div>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. <input type="checkbox"/>
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 2009, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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 (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, claim certain credits, adjustments to income, or an additional standard deduction

1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over \$166,800 (\$83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) 1 \$ _____

2 Enter: $\left\{ \begin{array}{l} \$11,400 \text{ if married filing jointly or qualifying widow(er)} \\ \$ 8,350 \text{ if head of household} \\ \$ 5,700 \text{ if single or married filing separately} \end{array} \right\}$ 2 \$ _____

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

4 Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) 4 \$ _____

5 Add lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) 5 \$ _____

6 Enter an estimate of your 2009 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 \$3,500 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 line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 10 _____

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 \$50,000 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 4-9 below to calculate 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 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. 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

Table 2

Married Filing Jointly		All Others		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	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 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	910	35,001 - 90,000	910
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
18,001 - 22,000	3	19,001 - 26,000	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 26,000	4	26,001 - 35,000	4	330,001 and over	1,280	370,001 and over	1,280
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. 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 also 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 using it 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 federal law enforcement and intelligence agencies to combat terrorism.

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



For additional information consult your employer or:

Arkansas Individual Income Tax Section
Withholding Branch
P. O. Box 8055
Little Rock, Arkansas 72203-8055

AR4EC

STATE OF ARKANSAS Employee's Withholding Exemption Certificate

Print Full Name _____ Social Security Number _____

Print Home Address _____ City _____ State _____ Zip _____

How to Claim Your Withholding <i>Instructions on the Reverse Side</i>		Number of Exemptions Claimed
<p>Employee: File this form with your employer. Otherwise, your employer must withhold state income tax from your wages without exemptions or dependents.</p> <p>Employer: Keep this certificate with your records.</p>	1. CHECK ONE OF THE FOLLOWING FOR EXEMPTIONS CLAIMED	
	(a) You claim yourself. <i>(Enter one exemption)</i>	
	(b) You claim yourself and your spouse. <i>(Enter two exemptions)</i>	
	(c) Head of Household, and you claim yourself. <i>(Enter two exemptions)</i>	
	2. NUMBER OF CHILDREN or DEPENDENTS. <i>(Enter one exemption per dependent)</i>	
3. TOTAL EXEMPTIONS. <i>(Add Lines 1a, b, c and 2)</i> If no exemptions or dependents are claimed, enter zero		
4. Additional amount, if any you want deducted from each paycheck. <i>(Enter dollar amount)</i>		
5. I qualify for the low income tax rates. <i>(See reverse for details)</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Please check filing status: <input type="checkbox"/> Single <input type="checkbox"/> Married Filing Jointly <input type="checkbox"/> Head of Household		

I certify that the number of exemptions and dependents claimed on this certificate does not exceed the number to which I am entitled.

Signature: _____ Date: _____

Instructions for completing the Employee's Withholding Exemption Certificate

1. NUMBER OF EXEMPTIONS – (Husband and/or Wife) Do not claim more than the correct number of exemptions. However, if you expect to owe more income tax for the year, you may increase your withholding by claiming a smaller number of exemptions and/or dependents, or you may enter into an agreement with your employer to have additional amounts withheld. This is especially important if you have more than one employer, or if both husband and wife are employed.

2. DEPENDENTS – To qualify as your dependent (line 1 on the reverse side), a person must (a) receive more than 1/2 of their support from you for the year, (b) not be claimed as a dependent by such person's spouse, (c) be a citizen or resident of the United States, and (d) have your home as their principle residence and be a member of your household for the entire year or be related to you as follows: son, daughter, grandchild, stepson, stepdaughter, son-in-law or daughter-in-law; Your father, mother, grandparent, stepfather, stepmother, father-in-law or mother-in-law; Your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law or sister-in-law; Your uncle, aunt, nephew or niece (but only if related by blood).

3. CHANGES IN EXEMPTIONS OR DEPENDENTS – You may file a new certificate at any time if the number of exemptions or dependents INCREASES. You must file a new certificate within 10 days if the number of exemptions or dependents previously claimed by you DECREASES for any of the following reasons:

(a) Your spouse for whom you have been claiming an exemption is divorced or legally separated, or claims his or her own exemption on a separate certificate, or

(b) The support of a dependent for whom you claimed an exemption is expected to be less than half of the total support for the year.

OTHER DECREASES in exemptions or dependents, such as the death of a spouse or a dependent, do not affect your withholding until next year, but require the filing of a new certificate by December 1, of the year in which they occur.

4. Claim additional amounts of withholding tax if desired. This will apply most often when you have income other than wages.

5. You qualify for the low income tax rates if your total income from all sources are as shown below:

- (a) Single \$7,800 to \$11,400
- (b) Married filing jointly \$15,500 to \$16,200
- (c) Head of Household \$12,100 to \$16,200

EMERGENCY CONTACT INFORMATION

Employee Name: _____

SSN: _____

Location: _____

Name: _____

Relationship: _____

Address: _____

Telephone: _____

Telephone: _____

Name: _____

Relationship: _____

Address: _____

Telephone: _____

Telephone: _____

Name: _____

Relationship: _____

Address: _____

Telephone: _____

Telephone: _____

Physician: _____

Telephone: _____

**MAGNESS OIL COMPANY
EMPLOYEE DEDUCTION AUTHORIZATION**

Please check off one of the boxes below and sign.

- I elect to participate in the employee fountain drink policy by authorizing Magness Oil Company to deduct \$5.00 per payroll period from my wages. There are no adjustments for partial pay periods. I understand that this election allows me unlimited fountain drinks during working hours only in a company provided container.
- I do not wish to participate in the employee fountain drink policy. I agree to pay full price for any beverage purchased and will use another cashier to ring up the purchase.

This authorization shall remain in effect unless revoked in writing.

Employee Name

Employee Signature

Date

Payroll Deduction Authorization

I hereby state that I understand and agree to abide by the policies, procedures and guidelines of the Magness Oil Company Instruction Manual as well as any other instructional documentation presented to me during my employment with Magness Oil Company.

I hereby agree to reimburse Magness Oil Company for losses or damages incurred by Magness Oil Company due to my failure to follow policy, procedure, guideline or instruction.

I hereby authorize Magness Oil Company to withhold from my paycheck the amounts necessary to reimburse Magness Oil Company for losses or damages incurred by Magness Oil Company due to my failure to follow policy, procedure, guideline or instruction.

My signature below indicates that I have read, understand and agree with the statements presented above.

Employee's Printed Name

Employee's Signature

Date

EMPLOYMENT MEDICAL HISTORY

The following questions have been determined to be required for a bona fide occupational qualification.

1. Have you ever had or have you now: (Please check each item)
- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| Broken or fractured bones..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Dislocated or injured joints..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fainting spells, convulsions..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Back trouble, back pain, injury..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart trouble..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Allergies..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Nervous or mental problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Frequent headaches..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Problems with circulation..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Swelling of Hands or Feet..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rupture or Hernia..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Head injury or concussion..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Dizziness or motor dysfunction..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chest Pain..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Bleeding tendency..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Thrombophlebitis or phlebitis..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Varicose veins..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any communicable disease..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
- If "Yes" to any of the above please describe: _____

2. Have you ever used addicting drugs or been treated for drug abuse or excessive use of alcohol?..... Yes No
3. Are you currently on any work restriction because of a medical problem?..... Yes No
4. Have you ever been hospitalized as the result of a back problem?..... Yes No
5. Have you ever had any injury to, or pain or swelling in any of the following:..... Yes No
(designate which) Shoulders___ Arms___ Wrists___ Knees___ Feet___
6. Have you ever had tennis elbow or a sore elbow?..... Yes No
7. Have you ever had video game wrist or a sore wrist?..... Yes No
8. Have you ever had a trick knee, torn cartilage, or any trouble with your knees?..... Yes No
9. Do you have, or have you had, any trouble with your feet?..... Yes No
10. Have you ever had a head injury or a whiplash injury to your neck?..... Yes No
11. Are you allergic to anything?..... Yes No
12. Have you ever:
- | | | |
|---|------------------------------|-----------------------------|
| a. Received worker's compensation benefits as a result of a work related injury?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Received disability insurance payments?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Received disability benefits from the government?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Been unable to do a particular work because of an emotional disability?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

The above answers are correct to the best of my knowledge and belief and I hereby authorize Magness Oil to verify any of the above facts by whatever means necessary at this time or in the future.

Signed _____ Date _____

MAGNESS OIL COMPANY CRIMINAL BACKGROUND CHECK

I hereby state that I understand Magness Oil Company has a policy to run a criminal background check on any person that applies for employment and that will be considered for a position.

I hereby agree to let Magness Oil Company run the criminal background check on myself.

My signature below indicates that I have read, understand, and agree with the statement presented above.

Employee's Printed Name

Employee's Signature

Date

DRUG & SUBSTANCE ABUSE CONSENT

Magness Oil Company, in connection with its desire to have a Drug-Free Work Place, has the following Drug and Substance Abuse Policy:

STATEMENT:

Magness Oil Company prohibits the illegal use, possession, transport, promotion or sale of drugs, drug paraphernalia and the unauthorized use of alcoholic beverages during working hours at any facility owned or operated the Company or at any other facility at which an employee of the Company is authorized to be present while conducting business for the Company. A Company employee must not report for duty under the influence of any drug, alcoholic beverage, or other substance, including legally prescribed drugs and medicines which will in any way affect his/her work ability, alertness, coordination, or response or which will in any way risk the safety of others.

PRE-EMPLOYMENT:

Prior to employment, any potential employee must donate a urine specimen which will undergo a urinalysis drug screen test and physical exam and employment is dependent upon the results of these tests.

SEARCH:

During the course of employment, an employee may be subject to inspection for possession or use of unauthorized or illegal substances such as alcohol and drugs as required by our policies. The employee's entry into a presence on company owned or company controlled work sites, vehicles, or temporary authorized work sites is conditioned to the company's right to search any employee's property, including lunch boxes, baggage, and private vehicles (including trunks, glove compartments, etc.). By entering or being present on company owned or company controlled work sites, vehicles, or temporary authorized work sites, any employee is deemed to have consented to such searches, which may include periodic unannounced searches while on , entering, or leaving such facilities.

RANDOM SCREENING:

During the course of employment, an employee may be subject to taking periodic random drug screening tests to determine the presence of substances prohibited by this policy. A "positive" result from these screening tests (indicating the presence of one or more of these illegal or unauthorized substances) will result in the immediate termination of the employee's employment.

POST-ACCIDENT TESTING:

Every employee will donate a urine specimen as outlined above in "Random Screening" within twenty-four hours of reporting an accident on company owned or controlled work sites, vehicle, or temporary authorized work sites at a location approved by the company.

I have read Magness Oil Company's Substance Abuse Policy and understand that the policy is now in effect.

In applying for employment, I understand that I authorize Magness Oil Company to conduct through its designated physician or laboratory testing facility a drug screening test upon a urine specimen that I will donate for testing, as a requirement for employment. I understand that my urine specimen will be tested for the presence of drugs or drug metabolites. I further understand that the presence of one or more of these drugs or drug metabolites in my urine specimen may cause my rejection of further consideration for employment.

I understand Magness Oil Company's Substance Abuse Policy in regard to all conditions for employment: pre-employment, reasonable cause, random testing, biennial testing for drivers, and post accident testing. I understand that my refusal to submit to any part of the testing program outlined above will constitute voluntary termination of my employment.

Signed _____

Date _____