Fleet Personnel Corp.
D/B/A Fleet Operators Group
705 Cross St, P O Box 690
Russellville AL 35653
256-332-9576

QUALIFICATION FORM

Section 1 — MOTOR CARRIER INFORMATION

Motor Carrier Name: Barnes Transportation Services Inc. M.C. #:271116 DOT #: 548617

Address: 2309 Whitley Rd. City: Wilson State: North Carolina Zip: 27895

Phone: (800) 898-5897 Fax: (252) 291-2787 Contact Person: Mike Ward

Section 2 — CONTRACTOR INFORMATION

Titled Truck Owner Name: ____________________ Address: ______________________________

Contractor Name: __________________________ Social Security No: ______________ DOB: __________

Address: __________________________ City: _____________________ State: _____ Zip: _________

Phone: ______________ Fax: ______________ Cell: ______________ Contact Person: ______________

Driver's License Information:

License Number: ________________________ State: ________ CDL: _________ Standard: __________

Section 3 — TRACTOR/TRAILER INFORMATION

Tractor: Year: _____ Make: _______ Model_______ VIN#: __________________ Mileage: __________

Trailer: Year: _____ Make: _______ Model_______ VIN#: __________________ Market Value: _______

Motor Carrier's Assigned Unit Number: ________________

Minimum Weekly Mileage Requirement: 2250 Mileage Rate .0299 cpm

Contractors Signature____

Section 4 CONTRACTORS AGREEMENT

I certify that I am a legal Independent Contractor and holder of the lease agreement with the Motor Carrier.. I have fulfilled all requirements to work legally in the United States by being a citizen and/or being in full compliance with all federal laws and/or regulations regarding work eligibility. I am not now, nor will I or any driver of my vehicle under lease become an employee of the Motor Carrier or Fleet Personnel Corp./ Fleet Operators Group by participating in the Voluntary Worker's Compensation Employers Liability Program though Fleet Operators Group.

I acknowledge and understand that as a Contractor leased to and operating under the Motor Carrier's authority that the Motor Carrier and/or I are subject to the State Worker's Compensation Statue. I acknowledge and voluntarily accept as part of my lease with Motor Carrier, if approved, the Voluntary Worker's Compensation Employers Liability option provided through the blanket policy of Fleet Personnel Corp./ Fleet Operators Group to satisfy the State Workers Compensation Statue. I acknowledge and understand that if I /or my company employee (3) three or more persons I/or my company are subject to State Workers Compensation and employment laws. Contractor agrees to indemnify and save harmless Fleet Personnel Corp./Fleet Operators Group and/or Motor Carrier for loss or expense which Fleet or Motor Carrier may incur by reason of Contractors neglect or knowingly violates such laws or regulations, and in the event that for any reason now unforeseen, Fleet and/or Motor Carrier is considered to be liable under such circumstances.

Initial__________

How Fleet's Voluntary Worker's Compensation Insurance Applies:

1. This insurance applies to bodily injury by accident or bodily injury by disease. Bodily Injury includes resulting in death.
2. This insurance applies only while under dispatch of Motor Carrier.
3. The bodily injury must occur in the United States of America, its territories or possessions.
4. Injury must occur during the term of the Contractors Lease Agreement with Motor Carrier.
5. This insurance does not cover bodily injury intentionally sustained by Contractor or driver.
6. This insurance does not cover drivers of Contractor that fall under federal or state laws as employees of Contractor.

I acknowledge and voluntarily accept, understand and agree to the following requirements of Fleet's Blanket Worker's Compensation Program:

1. I understand that the coverage provided through Fleet Personnel Corp./ Fleet Operators Group, covers the Motor Carrier and the Contractor under lease to Motor Carrier and shall become effective on the 1st dispatch by Motor Carrier after date of this agreement and will be in effect until Contractors lease with Motor Carrier is cancelled or Fleet's Contract with Motor Carrier is cancelled.
2. Charges for Workers Compensation is mileage based with a minimum charge.
3. Workers Compensation charge calculation does not include fuel surcharges and accessorial fees paid to the Contractor or driver by Motor Carrier and will not be part of wage calculation in the event of a compensable injury.
4. Fleet Operators Group holds harmless Contractor from any audit by Fleets Insurer in regards to the 33 1/3 rule of Contractors 1099, issued by Barnes Transporatation Services Inc..
5. For reasons described in #2, #3 and #4, Contract Operator agrees that .30 cents per mile(Single Operation) and .16 cents per mile per driver (Team Operation) multiplied times the avg mileage ran while in program will be used to calculate and determine average weekly wage of a compensable injury. Contractor agrees that for any compensable injury that he or his attorney pursues benefits based on his 1099, and receives benefits based on his 1099, that Fleet Personnel Corp./ Fleet Operators Group will be entitled to invoice for any difference between 1099 wages and .30 cpm that program is based on. INT____________
6. Any Workers Compensation injury or illness requires a DOT drug screen.
7. All injuries must be reported as soon as possible to Motor Carrier and Fleet Personnel/ Fleet Operators Group.
8. All medical treatment (excluding emergency situations) must be approved by Fleet Operators Group.
9. I agree that as a condition of payment of compensation benefits that I receive for a compensable injury that I will transfer Rights of Recovery against others that may be responsible for my injury to fleet Personnel Corp./Fleet Operators Group and/or its insurer and will assist Fleet Personnel Corp./Fleet Operators Group and/or its insurer in enforcing these rights.
10. I will cooperate fully with Fleet Personnel Corp /Fleet Operators Group as to enable Fleet to comply with any state, federal, and administrative regulation of laws as may be required.
11. I agree that if any dispute arises over jurisdiction of workers compensation injury or illness it shall be governed by and according to the benefits provided by the State of Alabama with venue being in Franklin County.

I hereby certify that this Qualification Form for Fleet Personnel Corp./Fleet Operators Group was completed by me, and that all entries on it and information in it are true. I understand that the giving of any inaccurate, false, or misleading information on this Qualification Form can result in rejection of my participation in Fleet personnel Corp./Fleet Operators Group Programs.

CONTRACTORS SIGNATURE____ Date:__________________

Section 5 DRIVER INFORMATION

Driver's Name: ______________________________ Social Security No: ____________________ DOB: __________

Address: ________________________________ City: __________________________ State: _____ Zip: __________

Phone: ________________________ Fax: ______________________ Cell: ___________________

Driver's License Information:

License Number: _____________________________ State: _________ CDL: __________ Standard: ___________

Years of US Driving Experience: _____ Height: _____ Weight: _____

Type of Experience: Flats/Vans/Dumps/Reefers, ____

# of Violations Last 4 years: _______ # of Accidents Last 4 years: ________ Description of Accidents: __________________

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1. Have you been injured in a work-related accident? ___ Yes ___ No

   Date: ____________Employer_________________________________ City/ State ________________________

   Date:____________Employer_________________________________City/State__________________________

2. Have you received medical treatment for any work related accident? ___ Yes ___ No

   Date: ____________ Medical Facility_____________________________ City/State________________________

   Date: _____________ Medical Facility_____________________________City/State________________________

3. Do you have a disability rating? ___ Yes ___ No If yes, give percentage? _____%

   Disabled area: _______________ Did you receive a settlement for your disability? ___ Yes ___ No

   If yes, Date: _____________ Employer_________________________________ City/State___________________

4. Do you have any health restrictions or limitations on the type of work you can perform? ___ Yes ___ No

   If yes, describe____

5. Are you presently taking any prescription medications? ___ Yes ___ No

   If yes, Medication________________________________ For____

Section 6	TEAM OPERATION ONLY

2nd Driver Information:

Driver's Name: ______________________________ Social Security No: ____________________ DOB: ___________

Address: ________________________________ City: __________________________ State: _____ Zip: __________

Phone: ________________________ Fax: ______________________ Cell: ___________________

Driver's License Information:

License Number: _____________________________ State: _________ CDL: __________ Standard: ____________

Years of US Driving Experience: _____ Height: _____ Weight: _____

Type of Experience: Flats/Vans/Dumps/Reefers, ____

# of Violations Last 4 years: _______ # of Accidents Last 4 years: ________ Description of Accidents: __________________

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1. Have you been injured in a work-related accident? ___ Yes ___ No

   Date: ____________Employer________________________________ City/ State ________________________

   Date:____________Employer_________________________________City/State__________________________

2. Have you received medical treatment for any work related accident? ___ Yes ___ No

   Date: ____________ Medical Facility_____________________________ City/State________________________

   Date: _____________ Medical Facility_____________________________City/State________________________

3. Do you have a disability rating? ___ Yes ___ No If yes, give percentage? _____%

   Disabled area: _______________ Did you receive a settlement for your disability? ___ Yes ___ No

   If yes, Date: _____________ Employer_________________________________ City/State__________________

4. Do you have any health restrictions or limitations on the type of work you can perform? ___ Yes ___ No

   If yes, describe____

5. Are you presently taking any prescription medications? ___ Yes ___ No

   If yes, Medication_______________________________ For____

Section 7 DRIVER AGREEMENT

I certify that I am DOT qualified and that I am in compliance with all applicable DOT requirements. I have fulfilled all requirements to work legally in the United States by being a citizen and/or being in full compliance with all federal laws and/or regulations regarding work eligibility. I am not now, nor will I become an employee of the Motor Carrier or Fleet Personnel Corp./Fleet Operators Group by participating in the Voluntary Worker's Compensation Employers Liability Program though Fleet.

I acknowledge and understand that as a Driver of Contractors vehicle leased to and operating under the Motor Carrier's authority that the Motor Carrier and/or Contractor are subject to the State Workers Compensation Statue.
I acknowledge and voluntarily accept as driver of Contractors vehicle, if approved, the Voluntary Worker's Compensation Employers Liability option provided through the blanket policy of Fleet Personnel Corp./Fleet Operators Group to satisfy the State Workers Compensation Statue. Initial__________

How Fleet's Voluntary Worker's Compensation Insurance Applies:

1. This insurance applies to bodily injury by accident or bodily injury by disease. Bodily Injury includes resulting in death.
2. This insurance applies only while under dispatch of Motor Carrier.
3. The bodily injury must occur in the United States of America, its territories or possessions.
4. Injury must occur during the term of the Contractors Lease Agreement with Motor Carrier.
5. This insurance does not cover bodily injury intentionally sustained by driver.
6. This insurance does not cover drivers of Contractor that fall under federal or state laws as employees of Contractor.

I acknowledge and voluntarily accept, understand and agree to the following requirements of Fleet's Blanket Worker's Compensation Program:

1. I understand that the coverage provided through Fleet Operators Group, covers the Motor Carrier and the Contractor under lease to Motor Carrier and shall become effective on the 1st dispatch by Motor Carrier after date of this agreement and will be in effect until Contractors lease with Motor Carrier is cancelled or Fleet Operators Group Contract with Motor Carrier is cancelled
2. Charges for Workers Compensation is mileage based with a minimum charge.
3. Workers Compensation charge calculation does not include fuel surcharges and accessorial fees paid to the Contractor or driver by Motor Carrier and will not be part of wage calculation in the event of a compensable injury
4. For reasons described in #2 and #3, As driver for Contractor I agrees that .30cents per mile(Single Operation)and .16 cents per mile per driver (Team Operation) multiplied times the avg weekly mileage ran while in program will be used to calculate and determine average weekly wage of a compensable injury. Driver Agrees that for any compensable injury that he or his attorney pursues benefits based on his full 1099, and receives benefits based on his 1099, that Fleet Personnel Corp./Fleet Operators will be entitled to invoice contractor for any difference between 1099 wages and .30cpm that program is based on. INT______________
5. Any Workers Compensation injury or illness requires a DOT drug screen.
6. All injuries must be reported as soon as possible to Motor Carrier or Fleet.
7. All medical treatment (excluding emergency situations) must be approved by Fleet.
8. I agree that as a condition of payment of compensation benefits that I receive for a compensable injury that I will transfer Rights of Recovery against others that may be responsible for my injury to Fleet Personnel Corp./ Fleet Operators Group and/or its insurer and will assist Fleet Personnel Corp./ Fleet Operators Group and/or its insurer in enforcing these rights.
9. I will cooperate fully with Fleet Personnel Corp./ Fleet Operators Group as to enable Fleet to comply with any state, federal, and administrative regulation of laws as may be required.
10. I agree that if any dispute arises over jurisdiction of a workers compensation injury or illness and cannot be resolved by Motor carriers domicile it shall be governed by and according to the benefits provided by the State of Alabama with venue being in Franklin County.

I hereby certify that this Qualification Form for Fleet Personnel Corp./ Fleet Operators Group was completed by me, and that all entries on it and information in it are true. I understand that the giving of any inaccurate, false, or misleading information on this Qualification Form can result in rejection of my participation in Fleet Operators Group Programs.

CONTRACTORS DRIVER SIGNATURE____ Date:________________________

Section 8 CONTRACTOR INFORMATION RELEASE

I authorize the Release of the following documents toFleet personnel Corp./ Fleet Operators Group, as necessary: (1) all insurance documents related to me and/or my insured equipment., (2) my current Motor Vehicle Report, (3) any applicable medical records, (4) any test results in accordance with DOT regulations, (5) a copy of my contract with the Motor Carrier, (6) any documents related to my equipment, (7) and a copy of my Driver Qualification File, (8) PSP Driver Score Card, while under contract with the Motor Carrier.

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CONTRACTORS SIGNATURE

DATE: ______________________________

Section 9 DRIVER INFORMATION RELEASE

I authorize the Release of the following documents to Fleet Personnel Corp./ Fleet Operators Group, as necessary: (1) All documents related to any on the Job Injuries sustained by me, (2) my current Motor Vehicle Report, (3) any applicable Medical Records, (4) any Test Results in accordance with DOT regulations, (5) PSP Driver Score Card report, and (6) a copy of my Driver Qualification File, while under contract with the Motor Carrier.

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CONTRACTORS DRIVER SIGNATURE

DATE: ____________________________