Form W-4 (2001)

Purpose. Complete Form W-4 so your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

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 2001 expires February 18, 2002.

Note *You cannot claim exemption from withholding if (1) your income exceeds $750 and includes more than $250 of unearned income (e.g., interest and dividends) and (2) 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 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. They will help you figure the number of withholding allowances you are entitled to claim. However, you may claim fewer (or zero) allowances.

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 line E below.

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.

Two earners/two 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.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2001. Get Pub. 919 especially if you used the **Two-Earner/Two-Job Worksheet** on page 2 and your earnings exceed $150,000 (Single) or $200,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

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: • 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 $1,000 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 $1,500 of **child or dependent care expenses** for which you plan to claim a credit (**Note** *Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.*)	F ____
G	**Child Tax Credit** (including additional child tax credit): • If your total income will be between $18,000 and $50,000 ($23,000 and $63,000 if married), enter "1" for each eligible child. • If your total income will be between $50,000 and $80,000 ($63,000 and $115,000 if married), enter "1" if you have two eligible children, enter "2" if you have three or four eligible children, or enter "3" if you have five or more eligible children.	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 ____

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, have more than one job** and your combined earnings from all jobs exceed $35,000, or if you are **married and have a working spouse or more than one job** and the combined earnings from all jobs exceed $60,000, see the **Two-Earner/Two-Job 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

Employee's Withholding Allowance Certificate

▶ For Privacy Act and Paperwork Reduction Act Notice, see page 2.

OMB No. 1545-0010

2001

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 ☐ 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	4 If your last name differs from that on your social security card, check here. You must call 1-800-772-1213 for a new 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 2001, 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 certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

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.)	Office code (optional)	10 Employer identification number

Cat. No. 10220Q

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

DATE _____

NAME _____ SOCIAL SECURITY NUMBER _____

LAST FIRST MIDDLE

PRESENT ADDRESS _____

STREET CITY STATE ZIP

PERMANENT ADDRESS _____

STREET CITY STATE ZIP

PHONE NO. _____ REFERRED BY _____

EMPLOYMENT DESIRED

POSITION _____ DATE YOU CAN START _____ SALARY DESIRED _____

ARE YOU EMPLOYED _____ IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? _____

EVER APPLIED TO THIS COMPANY BEFORE? _____ WHERE? _____ WHEN? _____

EDUCATION	NAME AND LOCATION OF SCHOOL	YEARS ATTENDED	DATE GRADUATED	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
[redacted]				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

*THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967 PROHIBITS DISCRIMINATION ON THE BASIS OF AGE WITH RESPECT TO INDIVIDUALS WHO ARE AT LEAST 40 BUT LESS THAN 70 YEARS OF AGE.

GENERAL

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK

WHAT FOREIGN LANGUAGES DO YOU SPEAK FLUENTLY? READ WRITE

U.S. MILITARY OR NAVAL SERVICE _____ RANK _____ PRESENT MEMBERSHIP IN NATIONAL GUARD OR RESERVES _____

SPECIAL QUESTIONS

DO NOT ANSWER ANY OF THE QUESTIONS IN THIS FRAMED AREA UNLESS THE EMPLOYER HAS CHECKED A BOX PRECEDING A QUESTION THEREBY INDICATING THAT THE INFORMATION IS REQUIRED FOR A BONA FIDE OCCUPATIONAL QUALIFICATION OR DICTATED BY NATIONAL SECURITY LAWS, OR IS NEEDED FOR OTHER LEGALLY PERMISSABLE REASONS.

☐ HEIGHT _____ FEET _____ INCHES

☐ WEIGHT _____ LBS.

☐ CITIZEN OF U.S. _____ YES _____ NO

☐ DATE OF BIRTH* _____

☐ _____

*THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967 PROHIBITS DISCRIMINATION ON THE BASIS OF AGE WITH RESPECT TO INDIVIDUALS WHO ARE AT LEAST 40 BUT LESS THAN 70 YEARS OF AGE.

PHYSICAL RECORD:

DO YOU HAVE ANY PHYSICAL DEFECTS THAT PRECLUDE YOU FROM PERFORMING ANY WORK FOR WHICH YOU ARE BEING CONSIDERED?

WERE YOU EVER INJURED? GIVE DETAILS:

HAVE YOU ANY DEFECTS IN HEARING? IN VISION? IN SPEECH?

IN CASE OF EMERGENCY NOTIFY

NAME ADDRESS PHONE NO.

FORMER EMPLOYERS (LIST BELOW LAST FOUR EMPLOYERS, STARTING WITH LAST ONE FIRST)

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				
FROM				
TO				
FROM				
TO				

REFERENCES:

GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

	NAME	ADDRESS	BUSINESS	YEARS KNOWN
1				
2				
3				

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT MISREPRESENTATION OR OMISSION OF FACTS CALLED FOR IS CAUSE FOR DISMISSAL. FURTHER, I UNDERSTAND AND AGREE THAT MY EMPLOYMENT IS FOR NO DEFINITE PERIOD AND MAY, REGARDLESS OF DATE OF PAYMENT OF MY WAGES AND SALARY, BE TERMINATED AT ANY TIME WITHOUT ANY PREVIOUS NOTICE.

DATE SIGNATURE

INTERVIEWED BY DATE

DO NOT WRITE BELOW THIS LINE

REMARKS:

NEATNESS		CHARACTER	
PERSONALITY		ABILITY	

HIRED FOR DEPT. POSITION WILL REPORT SALARY WAGES

APPROVED: 1. 2. 3.

EMPLOYMENT MANAGER DEPT. HEAD GENERAL MANAGER

THIS FORM HAS BEEN DESIGNED TO COMPLY WITH STATE AND FEDERAL FAIR EMPLOYMENT PRACTICE LAWS PROHIBITING DISCRIMINATION ON THE BASIS OF AN APPLICANT'S SEX OR MINORITY STATUS. QUESTIONS DIRECTLY OR INDIRECTLY REFLECTING SUCH STATUS HAVE BEEN INCLUDED ONLY WHERE NEEDED TO DETERMINE A BONA FIDE OCCUPATIONAL QUALIFICATION OR FOR OTHER PERMISSIBLE PURPOSES. SUCH QUESTIONS ARE APPROPRIATELY NOTED ON THE APPLICATION. NOTWITHSTANDING THESE EFFORTS, THE MANUFACTURER OF THIS FORM ASSUMES NO RESPONSIBILITY AND HEREBY DISCLAIMS ANY LIABILITY FOR INCLUSION IN THIS FORM, OF ANY QUESTIONS UPON WHICH A VIOLATION OF STATE AND FEDERAL FAIR EMPLOYMENT PRACTICE LAWS MAY BE BASED.

ACKNOWLEDGEMENT AND RELEASE
FOR
ALCOHOL/DRUG/SUBSTANCE ABUSE POLICY
AND TESTING PROGRAM

I have been told and understand that my employer has a policy that employees under influence of alcohol or chemical substances during working hours may be immediately discharged.

I agree that under appropriate circumstances, particularly if I am involved in an accident during working hours, I may be required and will submit to a test administered by a qualified authority that will determine if alcohol or chemical substances are present. I understand that positive results of this test can effect my eligibility for workers' compensation benefits.

I further understand that employment and continued employment depends upon my agreement to submit at any time and without prior notice to a drug/alcohol screen. I further understand that refusal to submit voluntarily to such tests or the detection of the presence of alcohol or drugs by such a test will result in my immediate discharge.

This policy has been read to me and I fully understand it.

NAME: _____ DATE: _____

WITNESS: _____ DATE: _____

I do hereby authorize my employer or representative of my employer to obtain medical reports, records, or tests which indicate the presence of alcohol or chemical substances in my body.

I agree that a photostat of this authorization be accepted if necessary.

NAME: _____ DATE: _____

WITNESS: _____ DATE: _____

COMPANY SAFETY POLICY

This company is committed to safety, and has taken steps to protect you from injury on the job.

Your help is vital for your own protection. Please observe the following safety rules at all times.

1. NO ALCOHOL OR DRUGS WILL BE USED ON THE JOB AT ANY TIME.
2. REPORT ALL JOB ACCIDENTS THE SAME DAY THE ACCIDENT HAPPENS.
3. ALL NON-EMERGENCY TREATMENT FOR ACCIDENTS MUST BE AUTHORIZED BY ALL SUPERVISORS FIRST.
4. WEAR SEAT BELTS AT ALL TIMES IN COMPANY VEHICLES.
5. YOU ARE RESPONSIBLE FOR KEEPING THE AREA WHERE YOU WORK CLEAN AND NEAT AT ALL TIMES.
6. DO NOT REMOVE OR BYPASS ANY GUARDS ON ANY MACHINERY AT ANY TIME.
7. ASK YOUR SUPERVISOR IF YOU NEED ADDITIONAL EQUIPMENT OR INSTRUCTION TO GET THE JOB DONE SAFELY.
8. LIFT WITH YOUR LEGS, NOT YOUR BACK AND GET ASSISTANCE WITH LOADS OVER 50 LBS.
9. ADVISE YOUR SUPERVISOR OF ANY HAZARDOUS CONDITIONS.
10. FOLLOW ALL OTHER WRITTEN AND SPOKEN SAFETY RULES.

NOTE: Along with the 10 Safety Rules above, develop specific safety rules for your industry by involvement of your Supervisors.

I have read these rules, understand them and will obey them for my own benefit.

_____ _____

Signature Date

_____ _____

Supervisor Date

Where injury is caused by the willful refusal of the employee to use safety equipment or obey safety rules, the compensation benefits can be reduced by 25%. (Florida Statute 440.09.(4)

POST-JOB OFFER MEDICAL HISTORY STATEMENT

NOTICE TO APPLICANTS: In complying with the Americans with Disabilities Act, our company has made to you a *conditional* offer of employment. This medical history statement is *voluntary* of all applicants who apply for certain job categories with this employer. The purpose of this statement is to assist us with regard to knowledge about any pre-existing conditions/disabilities that may entitle our company to obtain reimbursement from the State of Florida Special Disability Trust Fund, under Florida Statute 440.49. Specifically, in the event that a pre-existing condition/ disability is aggravated by a future work accident while employed at our company, and Workers' Compensation benefits are paid out, we may receive partial reimbursement from the State of Florida. The information provided will be kept in confidence and maintained consistent with the terms of the Americans with Disabilities Act and will not be used to discriminate against qualified individuals with a disability in any phase of employment, including hiring, advancement, transfer, wages, job training, and/or under other terms, conditions or privileges of employment. The job offer which you have received from this employer is "conditioned" upon the results of this medical history statement and/or any job specific medical exam required.

Company: _____

Employee Name: _____

Social Security #: _____ Drivers License #: _____ State: _____

Home Address: _____ Length of time at this address: _____

MEDICAL HISTORY

Answer each question as stated below "Yes" or "No" by placing an "X" in the space provided. If your answer to any of these questions is "Yes", give additional details in the space provided below, including year of accident or illness, physician's name, hospitals where treated and description of medical problem.

Do you have any physical or mental disabilities which could interfere with the performance of your duties toward the position you have been offered? If Yes, please explain: _____ Yes _____ No

If Yes, what accommodations to your disabilities do you suggest?

Do you contemplate surgery, or are you now receiving or do you contemplate receiving treatment or medication that could interfere with the performance of your duties toward the position you have been offered? _____ Yes _____ No

Date of last physical examination _____

Name of physician _____

Do you have or have you ever had:

	YES	NO		YES	NO
1. Epilepsy	_____	_____	8. Cerebral Palsy	_____	_____
2. Diabetes	_____	_____	9. Multiple Sclerosis	_____	_____
3. Cardiac Disease (heart trouble)	_____	_____	10. Parkinson's Disease	_____	_____
4. Marie Strumpell Disease	_____	_____	11. Vascular Disorder	_____	_____
5. Amputation of foot, leg, arm or hand	_____	_____	12. Psychoneurotic disability following treatment in a recognized medical or mental institution for a period in excess of 6 months	_____	_____
6. Total loss of sight of one or both eyes or a partial loss of corrected vision of more than 75% bilaterally	_____	_____	13. Hemophilia	_____	_____
7. Residual disability from poliomyelitis	_____	_____	14. Chronic Osteomyelitis	_____	_____

	YES	NO
15. Ankylosis of a major weight-bearing joint		
16. Hyperinsulinism		
17. Muscular Dystrophy		
18. Thrombophlebitis		
19. Herniated intervertebral disc		
20. Surgical removal of an intervertebral disc or spinal fusion		
21. Total Deafness		
22. Mental Retardation		
23. Any permanent physical condition which constitutes a 20% impairment of a member or of the body as a whole		
24. Rheumatic Fever		
25. High Blood Pressure		
26. Varicose Veins or Leg Ulcer		
27. Chest Pain		
28. Tuberculosis		
29. Allergies		
30. Hay Fever or Asthma		
31. Skin Trouble		
32. Sleep Disorder		

	YES	NO
33. Smoke or Use Any Tobacco Products		
34. Reaction to Serum or Drug		
35. Kidney or Bladder Trouble		
36. Ulcers		
37. Head Injury		
38. Cancer		
39. Dizziness or Fainting Spells		
40. Arthritis or Rheumatism		
41. Knee Injury		
42. Backache		
43. Shoulder Injury		
44. Alcoholism		
45. Fluctuation of Weight		
46. Drug Addiction		
47. Severe Headaches		
48. Chronic Cough		
49. Shortness of Breath		
50. Nervous Breakdown		

MEDICAL RECORDS AND OTHER INFORMATION

I authorize any physician, medical practitioner, hospital, clinic or other health facility, to release any and all medical and non-medical information in its possession about me to my employer or its legal representative. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me. I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid as long as I am employed by this company.

All statements and information given in this health questionnaire are true and accurate to the best of my knowledge and belief. I have read and fully understand this form.

Name of Applicant (Printed) _____ Date: _____

Name of Applicant (Signature) _____

Witness/Interviewer _____ Date: _____

* *Florida Law prohibits discrimination based upon the filing of a Workers' Compensation claim.*

Have you ever had a workers' compensation injury?
Ha tenido usted alguna vez accidentes de trabajo? _____

Have you ever received a disability rating for any reason?
Ha sido usted alguna vez clasificado como desabilitado? _____

Have you ever received compensation or medical benefits under workers' compensation?
Ha recibido usted compensación o beneficios medicos por accidentes de trabajo? _____

Explain fully any Yes answer.
Explique completamente cualquier respuesta de Si. _____

I have been fully advised that if I am injured on the job regardless of how minor the injury may seem, I am to report that injury immediately to my supervisor
Yo he sido totalmente insaruido que si yo sufro algún accidente en el trabajo debo reportarlo inmediatamente a mi supervisor, aún cuando el accidente aparezca ser pequeño

YES	No
Si	*No*
☐	☐

I certify the above answers to be true and correct. I understand that any false or misleading answers to these questions will be sufficient reason for denial of benefits under the Florida Workers' Compensation Act, and basis for termination of employment. I also understand that my answers will be verified by investigation.

Yo certifico que lo declarado anteriormente es correcto. Reconozco que cualquier declaracion falsa puede ser suficiente para perder el derecho a los beneficios bajo la ley de Compensación a los Trabajadores de la Florida y daria base para la terminacion del empleo. También entiendo que mis respuestas serán verificadas e investigadas.

Applicant's Signature
Firma del Aplicante _____ Date *Fecha* _____

Witness
Testigo _____ Date *Fecha* _____

NOTE: If applicant is unable to read and write, he is to make his mark in the space for his signature. The witness is to certify that he has read the above requested information to the applicant and that the answers are those of the applicant. Sign in the space for witness to certify.
Si el aplicante no sabe leer y escribir, debe poner su marca en el espacio de la firma. El testigo debe certificar que ha leido la información del documento aplicante y que las preguntas han sido contestadas por este firme en el espacio del testigo.

THE TITAN ELECTRIC GROUP, INC.

COMPANY POLICY

October 1, 2002

Attn: THE TITAN ELECTRIC GROUP, INC. Employees

From: Chuck Berlinghoff

Please read the following information and sign this letter and return to the office as soon as possible.

Employee Solicitation of Other Employees

Employees are not allowed to engage in solicitation of any kind for any purpose during working time. This includes solicitation by an employee of another employee while either the person doing the soliciting or the person being solicited is on working time.

Employee Literature Distribution

Employees are not allowed to distribute literature of any kind for any purpose during working time in working areas.

Non-Employee Access

Persons not employed by our company are not allowed to solicit employees for any purpose on company property at any time, or to distribute literature of any kind on company property, or to be or remain in non-public areas of company property without permission from an authorized company representative.

Off-Duty Employee Access

Employees not on duty or scheduled for immediate duty are not permitted for any purpose to remain or be in work areas or other areas not open to the public.

Thank you for your prompt attention to this matter.

Sincerely,

Chuck Berlinghoff

2730-7 CLYDO ROAD • JACKSONVILLE, FLORIDA • 32207
PHONE: 904-367-0678 • FAX: 904-367-0544 • EC13003262

THE TITAN ELECTRIC GROUP, INC.

SAFETY POLICY STATEMENT

The management of this organization is committed to providing employees with a safe and healthful workplace. It is the policy of this organization that employees report unsafe conditions and do not perform work tasks if the work is considered unsafe. Employees must report all accidents, injuries, and unsafe conditions to their supervisors. No such report will result in retaliation, penalty, or other disincentive.

Employee recommendations to improve safety and health conditions will be given thorough consideration by our management team. Management will give top priority to and provide the financial resources for the correction of unsafe conditions. Similarly, management will take disciplinary action against an employee who willfully or repeatedly violates workplace safety rules. This action may include verbal or written reprimands and may ultimately result in termination of employment.

The primary responsibility for the coordination, implementation, and maintenance of our workplace safety program has been assigned to:

Name: Charles W. Berlinghoff
Title: President Telephone: (904) 367-0676/813-3611

Senior management will be actively involved with employees in establishing and maintaining an effective safety program. Myself or other membets of our management team will participate with you or your employee representative in ongoing safety and health program activities, which include:

- Promoting safety committee participation;
- Providing safety and health education and training; and
- Reviewing and updating workplace safety rules.

This policy statement serves to express management's commitment to and involvement in providing our employees a safe and healthful workplace. This workplace safety program will be incorporated as the standard of practice for this organization. Compliance with the safety rules will be required of all employees as a condition of employment.

Charles W. Berlinghoff, President _____ Date _____

2730-7 CLYDO ROAD • JACKSONVILLE, FLORIDA • 32207
PHONE: 904-367-0676 • FAX: 904-367-0544 • EC13003262

THE TITAN ELECTRIC GROUP, INC.

PROBATIONARY PERIOD FORM

I understand that if I am placed in employment I will be on a ninety (90) day probationary period and will be terminated for unsatisfactory job performance.

I can also be terminated for misconduct or violation of any safety rules and for excessive absenteeism.

Signed: _____

Date: _____

2730-7 CLYDO ROAD • JACKSONVILLE, FLORIDA • 32207
PHONE: 904-367-0676 • FAX: 904-367-0544 • EC13003262

Motor Vehicle Report

Consent Form

Please consider my signature below to be my written authorization for _____, a prospective employer and The Della Porta Group, Inc. to obtain a copy my motor vehicle report to determine my eligibility for hire and for insurance underwriting purposes.

Name: _____

DOB: _____

DL#: _____

Date: _____

Signed: _____

MVR RELEASE FORM

ATTN: MVR DEPARTMENT

I hereby authorize _____ and its agent to request and receive any motor vehicle or driving history record pertaining to me which may be in the files of any state or local Department of Motor Vehicles agency. They may share this information with companies, employer, etc., for purposes of hiring, employment, underwriting, securing insurance coverage or other lawful purpose.

Full Name Printed: _____
FIRST MIDDLE LAST

Address: _____

_____

Drivers Lic. #: _____ State: _____

Date of Birth: _____ Sex: ____ Male ____ Female

Social Security Number: _____

Today's Date: _____

Signature: _____

The Titan Electric Group, Inc. Vehicle Agreement

Upon assuming the position of _____ with The Titan Electric Group, Inc. (Hereinafter referred to as the Company), as appropriate, effective _____, I will be allowed to use a Company vehicle to perform my job duties. As such, the vehicle is a tool related to the performance of specific jobs and is never to be considered a part of compensation. Therefore, should I be transferred or promoted in the future to a position within the Company for which a vehicle is not deemed an appropriate or necessary tool, I will cease to have the use of the vehicle.

I agree to abide by the following when a Company vehicle is in my care, custody or control:

1. I will use the Company vehicle only for Company business and never for personal use unless specifically authorized, in writing, by my supervisor or another Company person having authority to authorize such use.

2. If personal use of the vehicle is specifically authorized, only I will drive the vehicle.

3. I will practice sound defensive driving techniques and otherwise exercise reasonable care in the operation of the Company vehicle.

4. When used for company business, only company employees or other persons being transported for business purposes will be allowed to ride in or enter the Company vehicle, and only other authorized company personnel will be permitted to drive it.

5. I will not drive the Company vehicle while consuming alcoholic beverages or other drugs or while under the influence of alcohol or other drugs, nor will I allow anyone else to do so. I understand that violation of this policy may mean termination of my employment.

6. I will obey all traffic laws, ordinances, and regulations pertaining to the operation of motor vehicles. I will pay any fines, parking tickets, or other assessments for violations of traffic laws, ordinances, or regulations imposed on me. I acknowledge fines paid by me for any violations of such motor vehicle laws, ordinances, or regulations are totally my responsibility and will not be reimbursed by the Company.

7. I will wear a seatbelt at all times and will require all passengers to do so as well. I understand that failure to do so will result in disciplinary action up to and including termination.

8. Prior to driving the vehicle, I will check tires, lights, wipers, turn signals, rear view mirrors, and brakes to be sure they appear to be in safe operating condition. If defects are noted, I will promptly report and/or have them repaired as appropriate.

9. In the event of an accident, I will promptly comply with the Company automobile accident reporting procedures.

10. I understand that if I am involved in an accident with a company vehicle and the Company's insurance carrier assumes responsibility for payment of resulting claims, I may be required to attend a Defensive Driving training course.

11. **I am aware that the Company's automobile insurance DOES NOT cover me when I am driving a non-company car for personal use, it only insures the Company vehicles. I understand that if I do not have my own personal auto policy, it is very important that I contact my agent to purchase Named Non-owner automobile insurance to cover me when driving other automobiles (vacation rentals, etc.)**

These policies have been fully explained to me and I understand the contents of the Company Vehicle Agreement. I am aware that the failure to abide by these policies will result in disciplinary action, up to and including termination of my employment with the Company.

The Titan Electric Group, Inc. Vehicle Agreement

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in two counterparts each of which constitute an original, effective this _____ day of _____, 20_____.

_____

(Employee Name)

By:_____ By:_____

(Signature) *(Company Authorized Signature)*

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136

Employment Eligibility Verification

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 of 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)*

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	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)*

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)*

Employee Agreement

I have read a copy of the Safety Policy of The Titan Electric Group, Inc.

I hereby certify that I understand and acknowledge the Safety rules and Regulations and will abide by these rules and policies.

_____	_____
(Employee Signature)	**(Please Print your name)**
_____	_____
(Social Security Number)	**(Date)**

Employee Name: _____

COMPANY DRUG POLICY

FOR

THE TITAN ELECTRIC GROUP, INC.

CHUCK BERLINGHOFF
PRESIDENT

NOTICE TO OUR EMPLOYEES

Dear Fellow Employee:

It is a fact of life that alcohol and drug abuse is widespread in today's society. Its causes are many and complex, but one thing is certain – the use, sale, purchase, dispensing, or possession of illegal drugs and the abuse of alcohol are inconsistent with the company's commitment to provide a safe and productive work environment for all of its employees and to continue to deliver the high quality products and service which have made us an industry leader.

While the company has no intention on intruding into the private lives of its employees, we recognize that serious involvement with drugs or alcohol eventually takes its toll on job performance. Our concern is that employee's report to work in a condition to perform their duties safely and efficiently in the interest of our clients, our fellow workers, the company, and themselves. Hopefully, if we all do our part, our efforts will carry over into our community and reinforce our demonstrated concern for the health and safety of everyone.

***Effective April 20, 1996 all employees will be subject to substance of abuse testing.**

Sincerely,

Chuck Berlinghoff
President

Employee Initials: _____

BACKGROUND:

The company recognizes the dangers that the use of alcohol and/or drugs can have on the performance of its employees and on the safety and security of its work environment. In order to maintain productivity and, especially, to protect the safety and well being of all employees, direct action must be taken when employees are under the influence of drugs and/or alcohol, or when employees are dispensing drugs and/or alcohol on company property.

The company recognizes that drug and/or alcohol abuse **(SUBSTANCE ABUSE)** is treatable and is committed to make an effort to assist current employees who may be experiencing problems due to substance abuse, by helping them to understand and correct it, while supporting approved rehabilitation efforts.

Additionally, under Public Law 100-690, Title V, in conjunction with Drug Free Workplace Act of 1988 and/or in compliance with the Drug Free Workplace, State of Florida Worker's Compensation Act 440FS, 440.102 (5) and 38F-9.001, and/or in compliance with the Department of Transportation regulations in this industry, the company is obligated to establish, and communicate its policy on Drug and Alcohol use to all employees.

POLICY:

1. It is the policy of the company to maintain drug free workplace as a condition of continued employment. All employees must abide by the terms of this policy.

2. The use, sale, manufacture, distribution, purchase, possession, dispensing, or being under the influence of, illegal drugs, non-prescribed controlled substance, or alcohol on company property, while on company business, or while operating a company-owned or leased vehicle is strictly prohibited. Employees found to be in violation of this policy will be subject to discipline up to and including termination of employment. Any illegal drugs found on company property will be turned over the appropriate law enforcement authorities.

3. In order to detect the use of these substances, as described above, employees may be directed to submit to a urinalysis drug test, a blood test, and/or breath test. Individuals under the influence of alcohol, or with illegal or non-prescribed controlled drugs in their system are in violation of this policy and will be subject to discipline up to and including termination of employment.

The use of alcoholic beverages by company employees on company premises or on company assignments may take place during an approved company function.

Employee Initials: _____

IMPORTANT NOTE:

"The authorization of alcoholic beverages at such functions, DOES NOT relieve employees from the responsibility of exercising moderation and judgement so as not to represent a danger to themselves, other employees, the general public, or the company's reputation."

4. The use of legal drugs, prescribed by a licensed physician, for a specific treatment purpose will not result in disciplinary action. Some such prescriptions can have a direct impact on vigilance, judgement, and coordination. It is important, particularly in safety-sensitive assignments involving the operation of motor vehicles or machinery, for example, for the company to assure itself that there is not a threat to safety as a result of such medication. Therefore, an employee who must use prescribed drugs during work and whose physician advises that performance or behavior could be negatively affected by such use, must report this fact to his or her manager, along with acceptable medical documentation. The manager, in conjunction with the Personnel Department, will determine if temporary light duty assignment is appropriate.

5. Employees experiencing problems as a result of substance abuse should contact the Personnel Department for referral for treatment and/or counseling. This discussion will be kept confidential and will have no influence on appraising an employee's work performance. Work performance alone, not the fact that an employee seeks treatment is to be the basis of all performance evaluation. At the company's discretion, an employee may be granted unpaid medical leave to undertake drug or alcohol rehabilitation treatment in accordance with short-term disability policy #6-3. Such employee must cooperate fully with the approved treatment and/or counseling program and will not be permitted to return to work until a satisfactory release from the treatment program is presented to the Personnel Department certifying that the employee is capable of returning to work and has met the requirements of the program to date. An employee who undergoes treatment under this policy will be required to sign and comply with the substance abuse commitment letter. Upon returning to work, such employee will be subject to random testing to verify recovery for substance abuse and failure to take or pass a random test will result in termination of employment.

6. The company will utilize a urinalysis drug test, blood test, and/or breath test under the following circumstances:

   6-1 For all applicants prior to employment and/or routine fitness for duty.

   6-2 For current employees on a for-cause basis where there is reasonable suspicion that an employee has violated this policy. Testing will only be done with the approval of company Director of Personnel.

Employee Initials: _____

6-3 Upon return to work following treatment of 8 weeks for substance abuse, testing will be conducted on a random basis for at least one year and may include testing of the hair for drug use history.

6-4 When an employee suffers an injury during the course of and in the scope of his or her employment, and an employer has reasonable suspicion that the employee has caused or contributed to an accident, Meadows Electric, Inc. may test for the presence of alcohol or drugs in his or her system pursuant to the applicable provision.

6-5 Random Testing – When random testing is required by the employer, random selection will be computer generated by an outside contractor selected for this purpose, and will be fair and equal for all employees.

7. In addition to the aforementioned and/or in pursuant to the drug free workplace program under the Florida Worker's Compensation Act which stipulates that an employee injured in the course, and scope of his employment, and test positive for substances described in this policy, forfeits his/her eligibility for medical and indemnity benefits under the Florida Worker's Compensation Act. (Refusal to take a drug or alcohol test will result in forfeiture of either his/her eligibility for medical and indemnity benefits under the Florida Worker's Compensation Act, and be subject to automatic termination of employment.

8. Employee or job applicant who receives a positive confirmed drug test may contest or explain the result to the employer within five working days of receipt of the written test results from the employer.

9. It is the employee or job applicant's responsibility to notify the laboratory of any administrative or civil actions which he plans as a result of test.

10. It is the right of the employee to consult the testing laboratory for technical information regarding the effects of prescription and non-prescription medication on the drug test.

11. Any employee who is either arrested, indicted, or convicted or a work-related drug or alcohol related violation, must report this information to the Personnel Department no later than five (5) days after such arrest, indictment, or conviction. An employee who is convicted of a work-related drug or alcohol related charge, or an employee who is arrested or indicted of a work-related drug or alcohol related charge, where an independent company investigation finds a violation of this policy, will be subject to discipline, up to and including termination of employment. An unpaid leave of absence may be considered depending upon the severity of the situation.

Employee Initials: _____

Employee Initials: _____

12. The company will screen all or part of samples on the following drug panel:

Amphetamines	1000 ng/ml
Barbiturates	300 ng/ml
Benzodiazepines	300 ng/ml
Benzoylecgonine (Cocaine Metabolite)	300 ng/ml
Cannabinoids (THC, Marijuana)	100 ng/ml
Methadone	300 ng/ml
Methaqualone (Quaaludes)	300 ng/ml
Opiates	300 ng/ml
Phencyclidine (PCP, Angle Dust)	25 ng/ml

A positive finding will generate a confirmation through GC/MS and the results will be kept confidential. A copy of any positive test result will be provided to the subject employee and/or applicant within five (5) working days of receipt of the same by the company.

Payment for all required drug tests, pre-employment, reasonable suspicion, and/or routine fitness for duty shall be paid and/or reimbursed by the company.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The reasons for drug experimentation, such as curiosity and social pressure, have different reasons than those for occasional drug use. Dependency and fear of withdrawal are different still. The company and management will provide information of drug awareness to encourage the absence of substance abuse.

Welcome to THE TITAN ELECTRIC GROUP, INC.!

Sincerely,

Chuck Berlinghoff
President

JACKSONVILLE AREA DRUG AND ALCOHOL TREATMENT LOCATIONS

NAME	ADDRESS	TELEPHONE
Care Unit of Jax. Beach	1320 Roberts Dr. Jax. Beach, FL 32250	904-241-5133
Gateway Community Services, Inc.	555 Stockton St. Jax., FL 32204	904-387-4661
River Region Human Services, Inc.	421 W. Church St. Jax., FL 32204	904-359-6571
Guidance Clinic	8280-8 Princeton St. Blvd. Jax., FL 32256	904-730-7575
Chemical Dependency	2023 Ernest St. Jax., FL 32204	904-355-7099
CPC St. Johns River Hosp.	6300 Beach Blvd. Jax., FL 32216	904-724-9202
St. Augustine Psychiatric	200 River Haven Way St. Augustine, FL 32086	904-824-9800
Oak Medical Center	8889 Corporate Square Ct. Jax., FL 32216	904-725-7073
Straight, Inc.	4241 Baymeadows Rd. Jax., FL 32216	904-733-0039
Methodist Pathway Treatment Center	580 W. Eighth St. Jax., FL 32209	904-798-8250
Center for Life	11820 Beach Blvd. Jax., FL 32216	904-642-6680
Enpoint	5847 Luella St. Jax., FL 32207	904-346-3403
Jacksonville Metro Treatment Center	5830 N. Main St. Jax., FL 32208	904-764-6554
Alpha Counseling	4130 Salisbury Rd. Jax., FL 32216	904-281-0623

Employee Initials: _____

NAME	ADDRESS	TELEPHONE
Greenfield Center	1551 Riverside Ave. Jax., F: 32204	904-353-3784
Charter-By-The Sea	2636 Oak St. Jax., FL 32204	904-388-0553
Milestones in Recovery, Inc.	5143 University Blvd. W. Jax., FL 32207	904-448-1600
Koala Center	9250 Cypress Green Dr. Jax., FL 32216	904-730-2620
Community Counseling	1414 Kingsley Ave. Orange Park, FL 32273	904-269-4381
EAP Works	2705 Riverside Ave. Jax., FL 32205	904-384-9436
Ella B. Farshing	3000 Hartley Rd. Jax., FL 32257	904-268-4004
Resource EAP	1046 Riverside Ave. Jax., FL 32204	904-634-1700

Note: This list is provided for your information.

Employee Initials: _____

Employee Initials: _____

CONSENT FORM FOR DRUG TESTING

1. I understand that THE TITAN ELECTRIC GROUP, INC. has a policy against the use, possession or distribution of illegal drugs by its employment applicants and employees. I further understand that the company has adopted a drug-testing program as one method of implementing that policy.

2. I hereby consent to the taking of urine or blood samples by the company, or its agents, for purposes of the above drug testing program and to the testing of such samples by Laboratory Corporation of America or any other such drug testing laboratory designated by the company. I hereby further consent to the release of any test reports on such samples from the laboratory to the designated Medical Review Officer, which will report such to the personnel office of the company. The company may use all such reports with or without other information in their assessment of my employment application, and/or employment status.

3. I also understand that I have a legal right under the Confidentiality of Medical Information Act to receive a copy of this consent form.

4. I further understand that if I refuse to test, or test positive for the substances described within the company drug policy, I will forfeit (1) My medical and indemnity benefits under the Florida Worker's Compensation Act, and upon the exhaustion of the procedures in Florida Statute 440.102 (#5) Be subject to discipline up to and including termination of employment.

_____, 20___
Date

_____
Signature

_____
Print Name

_____
Address

_____

_____