Fastrak Express, Inc.
288 Stevens Road
Rising Sun, MD 21911
(410) 658-0523

"At-Will" Employment Application

The Company is an equal opportunity employer and will not discriminate against any applicant on the basis of any characteristic that is protected by local ordinance, state, federal law.

The Company is an "At-Will" Employer. This means that the employee may resign at any time and the employer may discharge at any time, for any reason and without notice. No supervisor or representative of the Company, other than owners has any authority to make any arrangements contrary to the preceding statement. No implied, oral, or written statements or agreements contrary to the express language of this at-will statement are valid unless they are in writing and signed by the owners of the business.

Name of Applicant: _____

Social Security Number: _____

Current Address: _____

_____

Municipality: _____

Telephone Number: _____

Are you legally authorized to work in the United States? Yes No

Can you provide original documents to establish this fact? Yes No

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Are you at least 18 years of age? Yes No

For what position are you applying? _____

When can you begin work? _____

Can you perform the essential functions of the job you are applying for? Yes No

Can you operate any special equipment? Yes No

If yes, please describe what kind: _____

General Questions

Do you have a valid Driver's License? Yes No

Have you ever been convicted of a felony within the last 3 years? Yes No

*If yes, explain when this occurred and the reason for conviction: _____
_____

*Note: A conviction will not necessarily disqualify applicant from the desired position.

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Employment History

Date: (Month/Year)	Name and address of employer	Salary	Position	Reason for leaving
From:				
To:				
From:				
To:				
From:				
To:				
From:				
To:				

Which of these jobs did you like best? _____

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I certify that the information in this application is true and complete to the best of my knowledge. I authorize the company to seek verification of all information contained here. I fully understand that any misrepresentation or omission of facts is grounds for disqualification for further consideration or my dismissal even if I am hired and the misrepresentation or omission is discovered at any time in the future.

In the event I am hired, I agree to abide by all company rules and regulations.

I further understand that my employment and compensation is for no specific period of time and may be terminated by the company or by me at any time, with or without cause, with or without previous notice.

_____ _____

Signature Date

Anti-Discrimination Policy

Fastrak Express, Inc. complies with all applicable state and local laws governing non-discrimination in employment in every location in which the Company has facilities.

Fastrak Express, Inc. provides equal employment opportunities (EEO) to all employees and applicants for employment without regard to race, color, religion, gender, sexual orientation, national origin, age, disability, genetic information, marital status, amnesty, or status as a covered veteran, in accordance with applicable federal, state and local laws.

This policy applies to all terms and conditions of employment, including, but not limited to, hiring, hiring, placement, promotion, termination, layoff, a recall, transfer, leaves of absence, compensation and training.

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Workers' Compensation Employee Notification

Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job. Your employer shall provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you are to select. You are to obtain treatment from one of the providers of your choice for ninety (90) days from the date of your first visit.

If you are faced with an immediate medical emergency, you may secure assistance from the closest hospital, physician or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on your employer's physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 9-day period you wish to change medical providers, you must once again re-visit your employer's panel and select a new physician. If you do not seek treatment from a provider on the panel list for the initial 90 days following your first visit, employer will not have to pay for the services rendered.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ, and you choose that option, the panel physician will abide by same for 90 days.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of the services rendered if such services are determined to have been unreasonable or unnecessary.

Any person who knowingly and with intent to defraud any insurance company/employer or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any act material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' compensation Act.

_____ _____

Employee Signature Date