

# APPLICATION FOR EMPLOYMENT

COMPANY Washingtons Movers LLC STREET ADDRESS 5100 81<sup>st</sup> Pl SW #B

CITY, STATE AND ZIP CODE Mukilteo WA 98275

APPLICANT'S NAME Leland Thomas Washington  
(First) (Middle) (Maiden Name, if any) (Last)

ADDRESS 5100 81<sup>st</sup> pl SW Mukilteo WA 98275 HOW LONG? 6 months  
(Street) (City) (State and Zip Code)

DATE OF BIRTH 5/24/89 PHONE 425-772-9840 SOCIAL SECURITY NO. [REDACTED]

PAST ADDRESSES (previous three years)

	STREET	CITY	STATE & ZIP CODE	HOW LONG?
1	<u>2440 Mukilteo Speedway #B</u>	<u>Mukilteo</u>	<u>WA 98275</u>	<u>4 Years</u>
2				
3				
4				

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS--DRIVER

DRIVER LICENSE	STATE	LICENSE NUMBER	TYPE	EXPIRATION DATE
	<u>WA</u>	<u>WDL35480D13B</u>	<u>License</u>	<u>5/24/21</u>

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.)	DATES		APPROX. # OF MILES (TOTAL)
		FROM	TO	
<u>STRAIGHT TRUCK</u>	<u>Box trucks</u>	<u>2010</u>	<u>2020</u>	<u>80K</u>
TRACTOR/SEMI-TRAILER				
TRACTOR/2 TRAILERS				
OTHER:				

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED)

DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	FATALITIES	INJURIES
<u>N/A</u>			

(Form 2 Rev. 10-2001)



Public Burden Statement: We estimate that the collection of information on this form will take an average of 15 minutes to complete. This information is required to process your application for a Commercial Driver's License (CDL) and is necessary for the Department of Transportation to issue a CDL. The information on this form is used to determine if you are eligible for a CDL and to determine the type of CDL you are eligible for. The information on this form is also used to determine if you are eligible for a Commercial Driver's License (CDL) and to determine the type of CDL you are eligible for. The information on this form is also used to determine if you are eligible for a Commercial Driver's License (CDL) and to determine the type of CDL you are eligible for.

Medical Examiner's Certificate

(For Commercial Driver Medical Certificate)

I certify that I have examined Joshua Viogant Joshua Viogant. In accordance with please check only one:
● the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) OR
○ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties.
If find this person is qualified, and, if applicable, only when (check all that apply):
□ Wearing corrective lenses □ Accompanied by a waiver/exemption
□ Wearing hearing aid □ Accompanied by a Skill Performance Evaluation (SPE) Certificate
□ Divided within an exempt territory (49 CFR 391.62) (Federal)
□ Qualified by operation of 49 CFR 391.64 (Federal)
□ Grandfathered from State requirements (State)
Medical Examiner's Certificate Expiration Date: 04/15/2022

Medical Examiner's Signature: [Signature] Date Certificate Signed: 04/15/2020
Medical Examiner's Telephone Number: (425) 774-8758
Medical Examiner's Name (please print or type): Guo, Jin
Medical Examiner's State License, Certificate, or Registration Number: PA10004502
Issuing State: WA
National Registry Number: 4441931058

Driver's Signature: [Signature] Issuing State/Province: WA
Driver's Address: 8127 220th St SW City: EDMUNDS State/Province: WA Zip Code: 98026
CLP/CODL Applicant/Holder: ○ Yes ● No

\*\*This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.\*\*

Redacted per RCW 42.56.230(7)(a)



**Public Burden Statement**

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 1 minute per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



U.S. Department of Transportation  
Federal Motor Carrier  
Safety Administration

### Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined **Last Name** Vallot Washington **First Name** Leland in accordance with (please check only one):

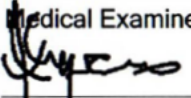
- the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) **OR**
- the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply):

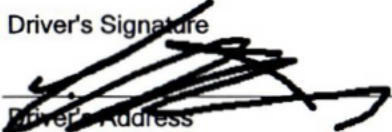

- Wearing corrective lenses
- Wearing hearing aid
- Accompanied by a \_\_\_\_\_ waiver/exemption
- Accompanied by a Skill Performance Evaluation (SPE) Certificate
- Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
- Qualified by operation of 49 CFR 391.64 (Federal)
- Grandfathered from State requirements (State)

**Medical Examiner's Certificate Expiration Date**

**04/15/2022**

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments embodies my findings completely and correctly, and is on file in my office.

<p><b>Medical Examiner's Signature</b> </p> <p><b>Medical Examiner's Name (please print or type)</b> Guo, Jin</p> <p><b>Medical Examiner's State License, Certificate, or Registration Number</b> PA10004502</p>	<p><b>Medical Examiner's Telephone Number</b> (425)774-8758</p> <p><input type="radio"/> MD    <input checked="" type="radio"/> Physician Assistant    <input type="radio"/> Advanced Practice Nurse <input type="radio"/> DO    <input type="radio"/> Chiropractor    <input type="radio"/> Other Practitioner (specify)</p> <p><b>Issuing State</b> WA</p>	<p><b>Date Certificate Signed</b> 04/15/2020</p> <p><b>National Registry Number</b> 4441932058</p>
---	--	--

<p><b>Driver's Signature</b> </p> <p><b>Driver's Address</b> Street Address: <u>5100 81st Pl SW Apt B</u>    City: <u>Mukilteo</u>    State/Province: <u>WA</u>    Zip Code: <u>98275-</u></p>	<p><b>Driver's License Number</b> </p>	<p><b>Issuing State/Province</b> WA</p> <p><b>CLP/CDL Applicant/Holder</b> <input type="radio"/> Yes    <input checked="" type="radio"/> No</p>
---	---	---

\*\*This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.\*\*



**Driving Record - [REDACTED]**  
 Abstract of Driving Record - Employment  
 This information is current as of 4/5/2020 9:09 AM

CERTIFIED

Driver Information	Address Information	License and ID Details
--------------------	---------------------	------------------------

DLN: [REDACTED] Last: VINCENT First: JOSHUA Middle: ROWLAND Suffix: DOB: 08/02/1993 Gender: M	Address on file	Personal Driver License: Status: L censed Issue: 08/01/2018 Expire: 08/02/2024 Original issue: 08/21/2013
---	-----------------	---

Restrictions	Endorsements
Description	Description
No restr ct ons	No endorsements

Reinstatements
Requirement
No requ rements

Document History					
Type	Issue	Expire	DLN	Issue type	Current Document
Persona Dr ver L cense	08/01/2018	08/02/2024	[REDACTED]	Renewa	Yes
Persona Dr ver L cense	02/04/2015	08/02/2018	[REDACTED]	Rep acement	No
Persona Dr ver L cense	08/21/2013	08/02/2018	[REDACTED]	Or g na	No
Instruct on Perm t	08/15/2013	08/15/2014	[REDACTED]	Renewa	No
Instruct on Perm t	09/06/2011	09/06/2012	[REDACTED]	Or g na	No

DLN History		
DLN	Start	End
[REDACTED]	09/06/2011	

Tickets			
<b>Description:</b> S93 - Speed ng <b>Violation date:</b> 06/24/2015 <b>Violation #:</b> 5Z0642570	<b>Finding date:</b> 10/22/2015 <b>Finding:</b> Gu ty <b>Court name:</b> K ng County D str ct Court	<b>Statute:</b> 46.61.400.05 <b>Electronic ticket:</b> No	<b>CMV:</b> No <b>Hazmat:</b> No <b>Fatality:</b> No <b>No test:</b> <b>Exempt veh:</b> No <b>Mental health:</b> No <b>16 Passenger:</b> No <b>Pass under 16:</b> No <b>Amended ACD:</b> No



# APPLICATION FOR EMPLOYMENT

COMPANY Washington Movers LLC STREET ADDRESS 5100 81st PL SW

CITY, STATE AND ZIP CODE Mukilton, WA 98276

APPLICANT'S NAME Joshua Rowland Vincent  
(First) (Middle) (Maiden Name, if any) (Last)

ADDRESS 8127 220th St SW, Edmonds, WA 98026 HOW LONG? 8  
(Street) (City) (State and Zip Code)

DATE OF BIRTH 08-02-1993 PHONE 425-210-7527 SOCIAL SECURITY NO. 534-29-0613

PAST ADDRESSES (previous three years)

	STREET	CITY	STATE & ZIP CODE	HOW LONG?
1	N/A			
2				
3				
4				

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS--DRIVER

DRIVER LICENSE	STATE	LICENSE NUMBER	TYPE	EXPIRATION DATE
	WA	WDL16523063B		08-02-2024

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.)	DATES		APPROX. # OF MILES (TOTAL)
		FROM	TO	
STRAIGHT TRUCK	straight truck	2012	2020	<del>1 million</del> 600K
TRACTOR/SEMI-TRAILER				
TRACTOR/2 TRAILERS				
OTHER:				

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED)

DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	FATALITIES	INJURIES
N/A			

(Form 2 Rev. 10-2001)

# WA WASHINGTON USA

## DRIVER LICENSE FEDERAL LIMITS APPLY

20 32182132G1333



4d LIC# [REDACTED]

9 CLASS

1 VINCENT

2 JOSHUA ROWLAND

3 DOB 08/02/1993

4a ISS 08/01/2018

8 8127 220TH ST SW

EDMONDS WA 98026-8121

15 SEX M

18 EYES BLU

16 HGT 5'-10"

17 WGT 150 lb

12 RESTRICTIONS

9a END NONE

NONE

4b EXP 08/02/2024

5 DD [REDACTED]

32182132G1333



Josh  
Redacted per RCW 42.56.230(5)

SAFETY PERFORMANCE HISTORY RECORDS REQUEST

**PART 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE**

1. (Print Name) Joshua B Vincent [Redacted] [Redacted]  
First M.I. Last Social Security Number

Hereby authorize: adams moving & janitorial 8-2-1993  
Date of Birth

Previous Employer Adams Moving Service Email: J.Vincent@adamsmoving.com  
 Street: 903 N 128th St Telephone: 206-251-1725  
 City, State, Zip: Seattle WA 98133 Fax No: \_\_\_\_\_

To release and forward the information requested by section 3 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from \_\_\_\_\_  
(employment application date)

To: Prospective Employer: Washington's Movers  
 Attention: Beland Washington Telephone: 425-245-2314  
 Street: 6100 81st SW #B  
 City, State, Zip: Mukilteo WA 98275

In compliance with §40.25(g) and 391.23(h), release of this information must be made in a written form that ensures confidentiality, such as fax, email, or letter.

Prospective employer's fax number: N/A

Prospective employer's email address: Washington'sMoversLLC@gmail.com

Joshua Vincent Applicant's Signature 5-29-20 Date

This information is being requested in compliance with §40.25(g) and 391.23

**PART 2: TO BE COMPLETED BY PREVIOUS EMPLOYER**

**ACCIDENT HISTORY**

The applicant named above was employed by us. Yes  No

Employed as Driver / Warehouse from (m/y) 5/2017 to (m/y) 9/2019

1. Did he/she drive motor vehicle for you? Yes  No  If yes, what type? Straight Truck  Tractor-Semitrailer   
 Bus  Cargo Tank  Doubles/Triples  Other (Specify) \_\_\_\_\_

2. Reason for leaving your employ: Discharged  Resignation  Lay Off  Military Duty   
 If there is no safety performance history to report, check here  sign below and return

ACCIDENTS: Complete the following for any accidents included on your accident register (5390.15(b)) that involved the applicant in the 3 years prior to the application date shown above, or check  here if there is no accident register data for this driver.

Date	Location	# Injuries	# Fatalities	Hazmat Spill
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Please provide information concerning any other accidents involving the applicant that were reported to government agencies or insurers or retained under internal company policies: \_\_\_\_\_

Any other remarks: \_\_\_\_\_

Signature: [Signature]  
 Title: OPERATIONS MANAGER Date: 5/28/2020

Redacted per RCW 42.56.230(7)(a)

WASH STATE DEPT OF HEALTH  
MEDICAL ASSISTANT EXAMINATION  
Application Form

1. Name (Last, First, Middle Initial)  
2. Address (Street, City, State, Zip)  
3. Telephone (Area Code, Number)  
4. Date of Birth (Month, Day, Year)  
5. Sex (Male, Female)  
6. Education (High School, College, University, etc.)  
7. Experience (Number of years, type of work)  
8. References (Name, Address, Phone Number)  
9. Signature (Printed Name, Signature)  
10. Date (Month, Day, Year)

Medical Assistant Examination  
Application Form

1. Name (Last, First, Middle Initial)  
2. Address (Street, City, State, Zip)  
3. Telephone (Area Code, Number)  
4. Date of Birth (Month, Day, Year)  
5. Sex (Male, Female)  
6. Education (High School, College, University, etc.)  
7. Experience (Number of years, type of work)  
8. References (Name, Address, Phone Number)  
9. Signature (Printed Name, Signature)  
10. Date (Month, Day, Year)

Medical Assistant Examination  
Application Form

1. Name (Last, First, Middle Initial)  
2. Address (Street, City, State, Zip)  
3. Telephone (Area Code, Number)  
4. Date of Birth (Month, Day, Year)  
5. Sex (Male, Female)  
6. Education (High School, College, University, etc.)  
7. Experience (Number of years, type of work)  
8. References (Name, Address, Phone Number)  
9. Signature (Printed Name, Signature)  
10. Date (Month, Day, Year)





**Driving Record - [REDACTED]**  
 Abstract of Driving Record - Insurance  
 This information is current as of 4/8/2020 7:44 AM

CERTIFIED

Driver Information	Address Information	License and ID Details
--------------------	---------------------	------------------------

DLN: [REDACTED] Last: VALLOT WASHINGTON First: LELAND Middle: T Suffix: DOB: 05/24/1989 Gender: M	Address on file	Personal Driver License: Status: L censed Issue: 06/25/2019 Expire: 05/24/2021 Original issue: 05/27/2010  State Identification Card: Issue: 05/04/2012 Expire: 05/24/2016 Original issue: 01/21/2006
---	-----------------	--

Restrictions			Endorsements	
Description	Lic type	Code	Description	Code
Ign t on nter ock dev ce requ red for 1 year and 156 days and Inter ock 180 Day Comp ance	PDL	J	No endorsements	
Probat onary cense requ red unt 7/14/2021	PDL	J		

Reinstatements
<b>Requirement</b> No requ rements

DLN History		
DLN	Start	End
[REDACTED]	06/25/2019	
[REDACTED]	01/21/2006	06/25/2019

# APPLICATION FOR EMPLOYMENT

COMPANY Washingtons Movers LLC STREET ADDRESS 5100 81<sup>st</sup> Pl SW #B

CITY, STATE AND ZIP CODE Mukilteo WA 98275

APPLICANT'S NAME Leland Thomas Washington  
(First) (Middle) (Maiden Name, if any) (Last)

ADDRESS 5100 81<sup>st</sup> pl SW Mukilteo WA 98275 HOW LONG? 6 months  
(Street) (City) (State and Zip Code)

DATE OF BIRTH 5/24/89 PHONE 425-772-9840 SOCIAL SECURITY NO. [REDACTED]

PAST ADDRESSES (previous three years)

	STREET	CITY	STATE & ZIP CODE	HOW LONG?
1	<u>2940 Mukilteo Speedway #B</u>	<u>Mukilteo</u>	<u>WA 98275</u>	<u>4 Years</u>
2				
3				
4				

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS--DRIVER

DRIVER LICENSE	STATE	LICENSE NUMBER	TYPE	EXPIRATION DATE
	<u>WA</u>	[REDACTED]	<u>License</u>	<u>5/24/21</u>

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN, TANK, FLAT, ETC.)	FROM	DATES TO	APPROX. # OF MILES (TOTAL)
STRAIGHT TRUCK	<u>Box trucks</u>	<u>2010</u>	<u>2020</u>	<u>80K</u>
TRACTOR/SEMI-TRAILER				
TRACTOR/2 TRAILERS				
OTHER:				

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED)

DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	FATALITIES	INJURIES
<u>N/A</u>			

(Form 2 Rev. 10-2001)



WA USA **WASHINGTON** DRIVER LICENSE  
FEDERAL LIMITS APPLY

20 D0625 192C1245

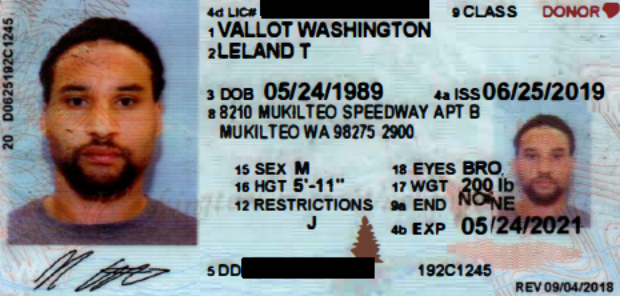
4d LIC# [REDACTED] 9 CLASS DONOR

1 VALLOT WASHINGTON  
2 LELAND T

3 DOB 05/24/1989 4a ISS 06/25/2019  
8 8210 MUKILTEO SPEEDWAY APT B  
MUKILTEO WA 98275 2900

15 SEX M 18 EYES BRO.  
16 HGT 5'-11" 17 WGT 200 lb  
12 RESTRICTIONS 9a END NONE  
J 4b EXP 05/24/2021

5 DD [REDACTED] 192C1245 REV 09/04/2018



Redacted per RCW 42.56.230(5)

SAFETY PERFORMANCE HISTORY RECORDS REQUEST

**PART 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE**

I (Print Name): Leland T Washington [Redacted]

First M.I. Last

Hereby authorize: 5/24/1989  
Date of Birth

Previous Employer: Adams Moving Service Email: adamsmoving1@gmail.com

Street: 903 N 128<sup>th</sup> St Telephone: \_\_\_\_\_

City State Zip: Seattle WA 98133 Fax No: \_\_\_\_\_

To release and forward the information requested by section 3 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from \_\_\_\_\_ (employment application date)

To: Prospective Employer: Washingtons Movers LLC

Attention: Leland Washington Telephone: \_\_\_\_\_

Street: 5100 81st Pl SW #B

City State Zip: \_\_\_\_\_

In compliance with §40.25(g) and 391.23(h) release of this information must be made in a written form that ensures confidentiality, such as fax, email or letter.

Prospective employer's fax number: \_\_\_\_\_

Prospective employer's email address: WashingtonsMoversLLC@gmail.com

Applicant's Signature: [Signature] Date: 5/29/20

This information is being requested in compliance with §40.25(g) and 391.23

**PART 2: TO BE COMPLETED BY PREVIOUS EMPLOYER**

**ACCIDENT HISTORY**

The applicant named above was employed by us Yes  No

Employed as Driver/Lead Mover (from (mth)) 7/2017 to (mth) 7/2018

1. Did he/she drive motor vehicle for you? Yes  No  If yes what type? Straight Truck  Tractor-Semitrailer   
 Bus  Cargo Tank  Double/Triples  Other (Specify) \_\_\_\_\_

2. Reason for leaving your employ: Discharged  Resignation  Lay Off  Military Duty   
 If there is no safety performance history to report, check here  sign below and return

ACCIDENTS: Complete the following for any accidents included on your accident register (§390.15(b)) that involved the applicant in the 3 years prior to the application date shown above or check  here if there is no accident register data for this driver.

Date	Location	# Injuries	# Fatalities	Hazmat Spill
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Please provide information concerning any other accidents involving the applicant that were reported to government agencies or insurers or retained under internal company policies: \_\_\_\_\_

Any other remarks: \_\_\_\_\_

Signature: [Signature]  
 Title: OPERATIONS MANAGER Date: 5/28/2020