

## **ATTACHMENT #16**

### **GST DRIVER INFORMATION**

**(29 Pages)**

EMPLOYEE NAME JOHN TIEMAN

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ POSITION DRIVER☒ APPLICATION 08-30-2011 DATE OF HIRE 01-30-2012☐ DRIVER'S LIC. COPY \_\_\_\_\_ EXPIRES 10-31-2013☒ SOCIAL SECURITY CARD \_\_\_\_\_☐ OTHER ID \_\_\_\_\_☒ PHYSICAL CARD 01-10-2012 EXPIRES 01-10-2013☒ MEDICAL RECORD 01-10-2012 FOLLOW UP NEEDED Y / **(N)**☒ DRUG TEST FORM 02-06-2012 D.O.B. \_\_\_\_\_

Notes: \_\_\_\_\_

☒ DRIVER'S ABSTRACT 01-30-2012 ☒ ENF POLICY 01-29-2012☐ BD OF ED AUTH CERT (Emergency Hire) \_\_\_\_\_ ☒ W/4 01-29-2012☒ Cx Hx (NJ Seal) 11-30-2011 Cx Hx Expires 11-30-2015 ☒ (I-9) 01-29-2012☐ OTHER RECORDS \_\_\_\_\_

Notes: \_\_\_\_\_

☒ EMERGENCY PHONE \_\_\_\_\_ WIFE NAME ARLENE TIEMANNJ STATE DRIVERS  
LICENSESOCIAL SECURITY  
CARD

# APPLICATION FOR EMPLOYMENT

(PRE-EMPLOYMENT QUESTIONNAIRE) (AN EQUAL OPPORTUNITY EMPLOYER)

## PERSONAL INFORMATION

DATE 8-30-11

NAME

TIE MAN  
LAST

JOHN  
FIRST

MICHAEL  
MIDDLE

SOCIAL SECURITY  
NUMBER

## PRESENT ADDRESS

PERMANENT ADDRESS

STREET

SAME

CITY

STATE

ZIP

PHONE NO

STREET

CITY

STATE

ZIP

ARE YOU 18 YEARS OF AGE OR OLDER? YES ☒ No ☐

ARE YOU PREVENTED FROM LAWFULLY BECOMING EMPLOYED  
IN THIS COUNTRY BECAUSE OF VISA OR IMMIGRATION STATUS? YES ☐ No ☒

## EMPLOYMENT DESIRED

POSITION

BUS DRIVER

DATE YOU  
CAN START

IMMEDIATELY

SALARY  
DESIRED

GOING RATE

ARE YOU EMPLOYED NOW? NO - RETIRED

IF SO MAY WE INQUIRE  
OF YOUR PRESENT EMPLOYER

EVER APPLIED TO THIS COMPANY BEFORE? NO

WHERE?

WHEN?

REFERRED BY

NEWSPAPER ADD.

EDUCATION	NAME AND LOCATION OF SCHOOL	*NO OF YEARS ATTENDED	*DID YOU GRADUATE	SUBJECTS STUDIED
GRAMMAR SCHOOL	<u>DELANCO PUBLIC SCHOOL DELANCO, N.Y.</u>	<u>9</u>	<u>YES</u>	
HIGH SCHOOL	<u>RIVERSIDE HIGH SCHOOL RIVERSIDE, N.J.</u>	<u>4</u>	<u>YES</u>	<u>COLLEGE PREP.</u>
COLLEGE	<u>BURL. CO. COLLEGE Pemberton, N.J.</u>	<u>1</u>	<u>NO</u>	<u>ACCOUNTING</u>
TRADE BUSINESS OR CORRESPONDENCE SCHOOL				

## GENERAL

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK

TOOK COL BOOK

## SPECIAL SKILLS

## ACTIVITIES (CIVIC, ATHLETIC, ETC.)

EXCLUDE ORGANIZATIONS, THE NAME OF WHICH INDICATES THE RACE, CREED, SEX, AGE, MARITAL STATUS, COLOR OR NATION OF ORIGIN OF ITS MEMBERS

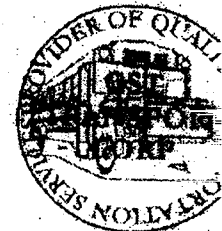
US MILITARY OR  
NAVAL SERVICE

RANK

PRESENT MEMBERSHIP IN  
NATIONAL GUARD OR RESERVES

\*THIS FORM HAS BEEN REVISED TO COMPLY WITH THE PROVISIONS OF THE AMERICANS WITH DISABILITIES ACT  
AND THE FINAL REGULATIONS AND INTERPRETIVE GUIDANCE PROMULGATED BY THE EEOC ON JULY 26, 1991

(CONTINUED ON OTHER SIDE)



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

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVE
FROM 1978	TRENTON IRONWORKER'S	\$23.00/Hr	IRONWORKER	RETIRED
TO 9-2007	TRENTON, N.J.			
FROM 1-67	HOBAN'S CORP.	\$14.00/Hr	PRODUCTION FOREMAN	TRY IRONWORK
TO 8-78	RIVERTON, NJ OUT OF BUSINESS			
FROM 8-63	ROBERT'S PLUMBING	\$2.50/Hr	COUNTER MAN DRIVER	BETTER JOB
TO 1-67	DELANCO, NJ OUT OF BUSINESS			
FROM				
TO				

WHICH OF THESE JOBS DID YOU LIKE BEST? IRONWORKING

WHAT DID YOU LIKE MOST ABOUT THIS JOB? DIFFERENT JOBS & LOCATIONS

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

NAME	ADDRESS	BUSINESS	YEARS ACQUAINTED
FR. CONNOR HAYNES		EPISCOPAL PRIEST	4
HARRY MCFARLAND		RETIRED PARKS & RECREATION MGR.	15
ROBERT OWENS		RETIRED SALES MGR.	38

THE FOLLOWING STATEMENT APPLIES IN: MARYLAND & MASSACHUSETTS. (Fill in name of state)

IT IS UNLAWFUL IN THE STATE OF \_\_\_\_\_ TO REQUIRE OR ADMINISTER A LIE DETECTOR TEST AS A CONDITION OF EMPLOYMENT OR CONTINUED EMPLOYMENT. AN EMPLOYER WHO VIOLATES THIS LAW SHALL BE SUBJECT TO CRIMINAL PENALTIES AND CIVIL LIABILITIES.

Signature of Applicant

C.D.

IN CASE OF

EMERGENCY NOTIFY

ARLENE M. TIRMAN

NAME

ADDRESS

PHONE NO.

"I CERTIFY THAT ALL THE INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE AND COMPLETE, AND I UNDERSTAND THAT IF ANY FALSE INFORMATION, OMISSIONS, OR MISREPRESENTATIONS ARE DISCOVERED. MY APPLICATION MAY BE REJECTED AND, IF I AM EMPLOYED, MY EMPLOYMENT I BE TERMINATED AT ANY TIME.

IN CONSIDERATION OF MY EMPLOYMENT, I AGREE TO CONFORM TO THE COMPANY'S RULES AND REGULATIONS, AND I AGREE THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME, AT EITHER MY OR THE COMPANY'S OPTION. I ALSO UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS OF MY EMPLOYMENT MAY BE CHANGED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME BY THE COMPANY. I UNDERSTAND THAT NO COMPANY REPRESENTATIVE, OTHER THAN ITS PRESIDENT, AND THEN ONLY, IN WRITING AND SIGNED BY THE PRESIDENT, HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIC PERIOD OF TIME TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING."

DATE

8-30-77

SIGNATURE

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY

REMARKS

NEATNESS

ABILITY

HIRED Yes ☐ No ☐

POSITION

DEPT

SALARY/WAGE

DATE REPORTING TO WORK

APPROVED: 1.

2.

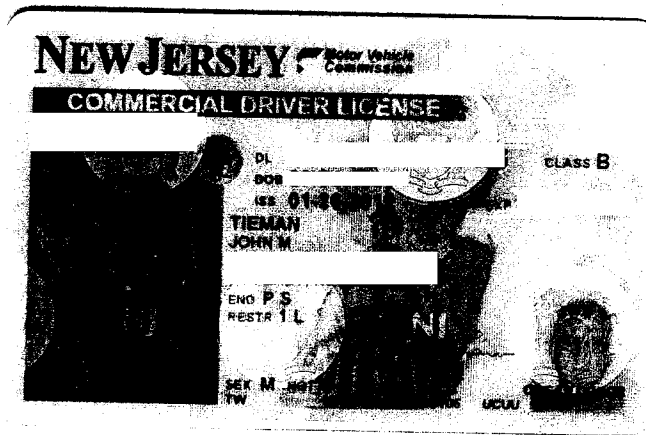
3.

EMPLOYMENT MANAGER

DEPT HEAD

GENERAL MANAGER

This form has been designed to strictly comply with state and federal fair employment practice laws prohibiting employment discrimination. This application for employment form is sold for general use throughout the United States. Tops assumes no responsibility for the inclusion in said form of any questions which, when asked by the employer of the job applicant, may violate state and/or federal law.



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-authorized 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 <u>TIEMAN</u>	First <u>JOHN</u>	Middle Initial <u>M.</u>	Maiden Name
Address (Street Name and Number)			Date of Birth (month/day/year)
City / State			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 of the United States  
☐ A noncitizen national of the United States (see instructions)  
☐ A lawful permanent resident (Alien #)  
☐ An alien authorized to work (Alien # or Admission #) until (expiration date, if applicable - month/day/year)

Employee's Signature

Date (month/day/year)

1-29-12

**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: _____		<u>State of NJ</u>		<u>Social Security</u>
Issuing authority: _____		<u>Drivers license</u>		
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) 1-30-12 and that to the best of my knowledge the employee is authorized 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 <u>Kathleen S. Becker</u>	Title <u>Mgr.</u>
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) <u>GST Transport 1897 Rt 38 Southampton, NJ 08088</u>		Date (month/day/year) <u>2-3-12</u>

**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 authorization.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized 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)

# MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined John Tieman in accordance with 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:

- ☒ wearing corrective lenses
- ☐ wearing hearing aid
- ☐ accompanied by a \_\_\_\_\_ waiver/exemption
- ☐ driving within an exempt intracity zone (49 CFR 391.62)
- ☐ accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with my attachment and my findings completely and correctly, and is on file in my office.

S		TELEPHONE	DATE 1-10-12
MEDICAL EXAMINER'S NAME (PRINT) Dr. Bill Stefanski		<input type="checkbox"/> MD <input type="checkbox"/> DO <input checked="" type="checkbox"/> Chiropractor	<input type="checkbox"/> Physician Assistant <input type="checkbox"/> Advanced Practice Nurse
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. / ISSUING STATE 38MCO0228700/NJ			
SIGNATURE OF DRIVER	DRIVER'S LICENSE NO.		STATE NJ
ADDRESS OF DRIVER			
MEDICAL CERTIFICATE EXPIRATION DATE 1/10/2013			

MOTOR CARRIER COPY

SEPARATE MOTOR CARRIER COPY BEFORE REMOVING LINER FROM LAMINATE

**American Driving Records, Inc.**  
**NEW JERSEY Driver Record - R3872**

PO Box 1970 Rancho Cordova, CA 95741-1970

Order Date: 01/30/2012

Seq #: 0

Host Used: Online  
 Rec Type: FIVE YEAR

Bill Code:  
 Reference:  
 License:

Name: TIEMAN, JOHN M  
 Address:  
 City, St:  
 As of:

Sex: Weight: DOB: Age:  
 Eyes: Height: Iss Date:  
 Hair: Exp Date: 10/31/2013

STATUS: VALID

**Violations/Convictions Failures To Appear Accidents**

TYPE VIOL	CONV	ACD	AVD	V/C	DESCRIPTION	SPEED	LOCATION/TICKET	ACCIDENT PT
VIOL 03/23/2007		F34	VE04	0467	OBSTRUCTING PASSAGE OF OTHER VEHICL		RIVERSIDE TWP.	-
ACCD 03/23/2007		-	AA01	POLC	** ACCIDENT **		NEW JERSEY	*ACC* -

**Suspensions/Revocations**

\*\*\* NO ACTIVITY \*\*\*

**License and Permit Information**

License: COMMERCIAL Issue: Expire: Status: VALID  
 Class: B VEH>26,000 GVWR W/VO TOWED UNIT<10,001 GVWR  
 Endorsement: PASSENGERS  
 Endorsement: SCHOOL BUS  
 Restriction: NO AIR BRAKES  
 Restriction: CORRECTIVE LENSES

**Miscellaneous State Data**

VIOL MISC. DATED: 03/23/2007 - THE EVENT IS ACTIVE ACC MISC. DATED: 03/23/2007 - THE EVENT IS ACTIVE  
 OUT OF STATE DRIVER HISTORY: NONE

END OF REPORT FOR TIEMAN, JOHN M

(CONTROL NUMBER: 2JQFR8)



Governor Chris Christie • Lt. Governor Kim Guadagno  
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## Criminal History Review

## Record Approval Date Status

TIEMAN, JOHN M	
PCN	
Approval Date	November 30, 2011
County Code	05
District Code	6138
School Code	000
Contractor Code	6138
Job Position	SCHOOL BUS DRIVER

Enter SSN to search for status of Record Approval Date.

This is a secure website. All SSNs are transmitted using an encrypted (SSL) connection. The web address for this site ought to start with *https*.

SSN:  -  - [Clear Status](#) | [Criminal History Review](#) | Counter: 825462[Contact Us](#) | [Privacy Notice](#) | [Legal Statement & Disclaimers](#) | [Accessibility Statement](#) **Department:** [Families](#) | [Students](#) | [Educators](#) | [Community](#) | [Programs & Services](#) | [Ask DOE](#) | [Join Our Mailing List](#)**Statewide:** [NJ Home](#) | [Services A to Z](#) | [Departments/Agencies](#) | [FAQs](#)  
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NJ Department of Education, PO Box 500, Trenton, NJ 08625-0500, (877)900-6960

Formerly Sagem Morpho Inc

(1) Originating Agency Number (ORI #) <b>NJ 930100Z</b>		(2) Category <b>ESK</b>		(3) Statute Number <b>NJSA 18A:39-19</b>	
(4) Reason for Fingerprinting <b>School bus driver employment</b>		(5) Document Type <b>RBI</b>		(6) Payment Information <b>Applicant pay 70.25 money ord</b>	
(7) Contributor's Case # (Unique Identifier) <b>056138</b>				(8) Miscellaneous	
(9) First Name <b>John</b>		(10) MI <b>M</b>	(11) Last Name <b>TIEMAN</b>		
(12) Daytime Phone Number		(13) Social Security Number		(14) Date of Birth	(15) Height <b>6-1</b>
(16) Weight <b>212</b>		(17) Maiden Name (if married female)		(18) Place of Birth (U.S. State - for US Citizen; Country for all others) <b>U.S. NJ</b>	
(19) Country of Citizenship <b>U.S.</b>					
(20) Home Address					
Address					
(21) Gender (Select one) Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Both <input type="checkbox"/>		(22) Hair Color (Indicate most predominant color, one only) <b>GRAY</b>		(23) Eye Color <b>HAZEL</b>	
(24) Race (Select one) A Asian/ Pacific Islander ( Includes Asian Indian) B Black C White ( Includes Hispanic/ Spanish Origin) D Unknown E American Indian / Alaska Native					
(25) Occupation <b>School Bus Driver</b>		(26) Employer (Name) <b>GST Transport, Corp.</b>			
Employer Address <b>1897 Rt. 38</b>		City <b>Southampton</b>			
State <b>NJ</b>		Zip <b>08088</b>			

**APPLICANT INFORMATION - READ THIS FORM CAREFULLY AND FOLLOW ALL INSTRUCTIONS TO COMPLETE THE FINGERPRINT PROCESS. You MUST present this completed form at your appointment to be FINGERPRINTED. NO EXCEPTIONS ALLOWED. Applicant without forms or with incomplete forms will not be printed.**

**IDENTIFICATION IS REQUIRED- ACCEPTABLE ID REQUIREMENTS -ID MUST include Photo, Name, Address (Home/ Employer) Date of Birth. Acceptable ID MUST be issued by a Federal, State, County or Municipal entity for Identification purposes. Example acceptable ID are: 1) Valid Photo Drivers License or Valid Photo ID issued by any State DMV or NJ MVC, 2) Passport. Acceptable on one (1) ID. Combinations of documents are |**

RECEIPT

SAGEM MORPHO, INC.

Date: Mon Nov 21 09:17:33 2011

 Applicant Name:  
 TIEMAN, JOHN M

 Fingerprinting Location:  
 CERRY HILL

Applicant ID#

 Payment Method:  
 MAJOR CREDIT CARD

 Payment Amount:  
 70.25

CUSTOMER COPY

red at the time of scheduling. Payment may be made via automatically be debited. An \$11 fee is charged to cover the business day prior to your scheduled appointment (Saturday without penalty if cancellation requirements are met. Inability to present proper ID, who fail to present this payer, or who are turned away because information on the refunded State and Federal search fees only.

hours per day, 7 days per week. For applicants who do not show up on a first call, first served basis Monday through Friday. Hearing operators are available. Hearing impaired center can make payment by money order at the fingerprinting center.

be confirmed by the call center agent or web confirmation while speaking with the operator. If you appear for the appointment and are not fingerprinted. If applicable, you will be charged the fee.

Your PCN number will be recorded when your fingerprinting has been completed. You MUST retain a copy of the form and a copy of the receipt provided to you by the Fingerprint Technician for your records. **NO RECEIPTS WILL BE PROVIDED AFTER THE DATE OF PRINTING.**

Applicant ID No.	Scheduled Site/ Date/ Time <b>Monday, November 21, 2011 9:05 AM</b>	PYMT Authorization <b>111111</b>	PCN
Agency Information #1 <b>10</b>	Agency Information #2		

**APPLICANTS MUST NOT ALTER, SHARE OR REUSE THIS FORM**

New Jersey  
Department of Education[AA&C Home](#)CRIMINAL HISTORY REVIEW UNIT (CHRU)  
ePAYMENT[Print](#)**Your AA&C form has been submitted successfully!**

(Your transaction number: 1320332288041, Your OPC ePayment confirmation number: 143657)

To check the status of your payment, visit the Official Payments Corporation (OPC) Web site at [https://www.officialpayments.com/pc\\_paym.jsp](https://www.officialpayments.com/pc_paym.jsp). Please be prepared to provide your e-mail address and your OPC ePayment confirmation number.  
Official Payments Corporation (OPC) Customer Service Department 1-800-487-4567

Please click on the MorphoTrak Inc link to schedule a fingerprinting appointment:  
[www.bioapplicant.com](http://www.bioapplicant.com)

**APPLICANT AUTHORIZATION AND CERTIFICATION (AA&C)  
NEW ADMINISTRATION FEE PAYMENT REQUEST****Applicant Information:**

Transaction ID: 1320332288041  
OPC Confirm No.: 143657  
Transaction Date: 2011-11-03 10:58  
Applicant Name: John M Tieman  
Social Security No.:  
Date of Birth:  
Sex: Male  
Race: White, Non-Hispanic  
Street Address :  
City:  
State: NEW JERSEY  
Zip:  
Job Category: School Bus Driver  
Driver's License No.:  
Driver's License Issued State: NEW JERSEY  
Driver's License Expiration Date:  
Driver's License Type: Initial  
School County: BURLINGTON  
Contractor: GST TRANSPORT CORP.  
Phone: 6092673380  
Email:

**Legal Certification:**

Notary Certification? Yes

**Payment Information:**

Credit Card: American Express  
Credit Card Number:  
Name as Appears on Card: Jonathan Brunt  
Expiration Date: 02/2014  
Total Pay Amount: \$11.00 (\$10 + \$1 Convenience fee)

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## EMERGENCY CONTACTS


Please give the name and number of at least two people we can call for you in the event of an illness or other emergency.

EMPLOYEE NAME: John Tieman

### Contacts:

1. Name: Arlene Tieman  
Telephone Number: \_\_\_\_\_ ext \_\_\_\_\_  
Alternate Number: \_\_\_\_\_ ext \_\_\_\_\_  
Relationship: Wife
2. Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ ext \_\_\_\_\_  
Alternate Number: \_\_\_\_\_ ext \_\_\_\_\_  
Relationship: \_\_\_\_\_
3. Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ ext \_\_\_\_\_  
Alternate Number: \_\_\_\_\_ ext \_\_\_\_\_  
Relationship: \_\_\_\_\_
4. Name: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ ext \_\_\_\_\_  
Alternate Number: \_\_\_\_\_ ext \_\_\_\_\_  
Relationship: \_\_\_\_\_

I have read and understand the Letter of January 1, 2008 (For Year 2008) concerning LAW ENFORCEMENT POLICY and the changes which are effective immediately.

signature 

 date 1-29-12

## ACKNOWLEDGEMENT

(This document will be placed in your personnel file)

I JOHN M TIEMAN have received the Employee Handbook and understand that it is not a contract of hire with GST. It is however, a guide to understanding the requirements of my employment. It is my responsibility to read the materials within and in accordance to the OPEN DOOR POLICY, any questions or ideas I may have regarding this handbook, may be directed in writing directly to the Management of GST.

I understand that any changes regarding this Handbook may be implemented at any time upon written decree and notification from the Company's owners.

signature

/

date

1-30-12

**BUS APPLICATION UNIT****INFORMATION FLYER AND DECLARATION**

To obtain a Commercial Driver License (CDL) with a passenger endorsement or a passenger/school bus endorsement, an applicant must be fingerprinted as part of the background records check. Even if a passenger endorsement is issued, the New Jersey Motor Vehicle Commission (MVC) reserves the right to deny the application upon review of your driver history record, the receipt of a criminal background report, or disqualifying medical/physical condition. Please refer to your CDL Manual for causes for disqualification or suspension of a passenger or passenger/school bus endorsement privilege.

**FINGERPRINTING PROCESS**

To schedule a fingerprint appointment, contact the State's fingerprint vendor, Sagem Morpho, toll-free at 877-503-5981, Monday through Saturday between 9 a.m. and 5 p.m. Hearing impaired scheduling is available by calling 800-673-0353. Web based scheduling is available at [www.bioapplicant.com/nj](http://www.bioapplicant.com/nj). The Sagem Morpho operator will ask each applicant for specific employment information as well as personal information. It is important that your name, date of birth, and eye color provided on written or electronic applications match the information on your driver license. In addition, be sure you have all the correct information from your employer concerning the position you are applying for, the Statute Number (noted in each applicable section below), and Originating Agency Number (ORI).

You must bring an acceptable form of photo identification to your scheduled appointment such as a federal, state or municipal ID, driver license or passport. Fees are payable by credit card or money order only.

**FOLLOW THE PROCEDURE THAT APPLIES TO YOU**

1. **SCHOOL BUS OPERATORS UNDER THE JURISDICTION OF THE DEPT. OF EDUCATION (N.J.S.A. 18A:39-19.1)**: When an appointment for your fingerprinting is made, your employer should provide you with a form containing specific identifying information that is required by Sagem Morpho. Upon application to the MVC Agency for the passenger/school bus endorsement, each applicant must submit a copy of the Dept. of Transportation physical examination form and this Declaration with all information completed. *If you leave employment as a bus driver under the Dept. of Education you will be required to be fingerprinted under N.J.S.A. 39:3-10.1.*
2. **SCHOOL BUS DRIVERS FOR PRIVATE/PAROCHIAL SCHOOLS OR DEPT. OF HUMAN SERVICES NOT UNDER THE JURISDICTION OF THE DEPT. OF EDUCATION (N.J.S.A. 39:3-10.1)**: If you are following this procedure, **you must be fingerprinted pursuant to N.J.S.A. 39:3-10.1**. Upon application to the MVC Agency for the passenger/school bus endorsement, each applicant must submit a copy of the Dept. of Transportation physical examination form and this Declaration with all information completed. *If you leave employment with the Dept. of Human Services or the Private/Parochial School and apply for employment with the Dept. of Education, you must be fingerprinted under N.J.S.A. 18A:39-19.1.*
3. **ALL PUBLIC TRANSPORTATION OPERATORS (BUSES & LIMOUSINES) (N.J.S.A. 39:3-10.1)**: If you are following this procedure, you will be fingerprinted under N.J.S.A. 39:3-10.1. Upon application to the MVC Agency for the passenger endorsement, each applicant must submit a copy of the Dept. of Transportation physical examination form and this Declaration with all information completed. *If you leave employment with public transportation and apply for employment with the Dept. of Education or Human Services, you must be fingerprinted in accordance with the laws governing school bus drivers under their jurisdiction.*

**DECLARATION**

I will ☒ will not ☐ (check one) be transporting school-age children under the jurisdiction of the Department of Education. (If you check "I will", you must follow procedure #1. If you check "I will not", you must follow procedure #2 or #3). I have read the above information and understand that should the MVC Bus Application Unit find that I am disqualified as a result of the review of my physical examination form, driver history record and/or criminal background check, the passenger endorsement along with the school bus endorsement will be subject to suspension.

PRINT NAME: JOHN M. TIEMAN DL#:

SOCIAL SECURITY#:

EMPLOYER'S NAME &amp; ADDRESS:

**GST Transport 1897 Rt 38 Southampton, NJ 08008**Check the one that applies to you: ☒ DOE ☐ DHS Day Care ☐ Private/Parochial School ☐ Public TransportationSIGNATURE: \_\_\_\_\_ DATE: 1-26-12

I, the applicant, certify that the statements on this declaration are correct.

\* Submission of your Social Security Number is required by N.J.A.C. 13:21-1.3 and it will be used to prevent errors, enforce federal and state laws and assist in the collection of motor vehicle fees.

## OPTIONAL EQUIPMENT

Vehicle Axles  
Trailer Axles  
Air Brakes

2 3  
1 2  
Y N

NEW JERSEY  
MOTOR VEHICLE COMMISSION  
COMMERCIAL DRIVER LICENSE SKILLS TEST

FACILITY

SCS

DATE

1-26-12

DRIVER LICENSE NUMBER:

APPLICANT NAME:

JOHN M TIEMAN

## PRETRIP INSPECTION:

(Give Applicant Memory Aid)

Fluid Leaks	<input checked="" type="checkbox"/>	Fuel Tank	<input checked="" type="checkbox"/>	Release Arm	<input checked="" type="checkbox"/>
Lights	<input checked="" type="checkbox"/>	Fuel Tank Leaks	<input checked="" type="checkbox"/>	Reflectors	<input checked="" type="checkbox"/>
Windshield	<input checked="" type="checkbox"/>	Exhaust System	<input checked="" type="checkbox"/>	Sig/Brake Light	<input checked="" type="checkbox"/>
Wipers	<input checked="" type="checkbox"/>	Air/Elec Lines	<input type="checkbox"/>	Landing Gear	<input type="checkbox"/>
Mirrors	<input checked="" type="checkbox"/>	Safety Latch	<input type="checkbox"/>	Doors/Ties	<input checked="" type="checkbox"/>

## SCORING PRETRIP

PASS if SCORE is

BUS 3 axles 26

2 axles 22

TRUCK 3 axles 24

2 axles 21

TRACTOR 3 axles 26

TRAILER: 4 axles 30

5 axles 34

## INTERIOR CHECK

NO	<input type="checkbox"/>	Safety Equipment	<input checked="" type="checkbox"/>	WHEELS	1 2 3 4 5
Steering play	<input checked="" type="checkbox"/>	Clutch/Gearshift	<input checked="" type="checkbox"/>	Rims	<input checked="" type="checkbox"/> 0 0 0
Light indicators	<input checked="" type="checkbox"/>	Oil Pressure	<input checked="" type="checkbox"/>	Tires	<input checked="" type="checkbox"/> 0 0 0
Horn	<input checked="" type="checkbox"/>	Parking Brake	<input checked="" type="checkbox"/>	Axle/Hub seals	<input checked="" type="checkbox"/> 0 0 0
				Lug Nuts	<input checked="" type="checkbox"/> 0 0 0

## BUS ONLY

Warning Lights	<input checked="" type="checkbox"/>	Passenger entry	<input checked="" type="checkbox"/>	Passenger exit	<input checked="" type="checkbox"/>
----------------	-------------------------------------	-----------------	-------------------------------------	----------------	-------------------------------------

SCORE:

27

PASS

FAIL [ ]

## BASIC CONTROL SKILLS

## RIGHT TURN

Pullups	0 1 2 3 4 5
Encroachments	0 1 2 3 4 5
Clearance	0 1 2 3 4 5

## STRAIGHT LINE BACKING

Pullups	0 1 2 3 4 5
Encroachments	0 1 2 3 4 5
STOP AT LINE	
Stop (2')	0 1

## ALLEY DOCK

Pullups	0 1 2 3 4 5
Encroachments	0 1 2 3 4 5
Rear Dock (2')	0 1

## SCORING BASIC CONTROL

FAIL if 12 or more errors

SCORE:

5

PASS

FAIL [ ]

## ROAD TEST

Maneuver		Evaluation Points (Circle Failures)				
[A]	[B]	[C]				
1. LEFT TURN						
Approach, Turning, Complete Turn If Stop		Traffic Ck	Signal	Decel	Coast	Lane
		Traffic Ck	Gears	Both Hands	Speed	Wide/Short
		Traffic Ck	Correct Ln	Signal	Accel	Right
		Stop ? [ ]	Necessary	Gap	Stop Line	Full Stop
2. LEFT TURN						
Approach, Turning, Complete Turn If Stop		Traffic Ck	Signal	Decel	Coast	Lane
		Traffic Ck	Gears	Both Hands	Speed	Wide/Short
		Traffic Ck	Correct Ln	Signal	Accel	Right
		Stop ? [ ]	Necessary	Gap	Stop Line	Full Stop
3. RIGHT TURN						
Approach, Turning, Complete Turn If Stop		Traffic Ck	Signal	Decel	Coast	Lane
		Traffic Ck	Gears	Both Hands	Speed	Wide/Short
		Traffic Ck	Correct Ln	Signal	Accel	Right
		Stop ? [ ]	Necessary	Gap	Stop Line	Full Stop
4. RIGHT TURN						
Approach, Turning, Complete Turn If Stop		Traffic Ck	Signal	Decel	Coast	Lane
		Traffic Ck	Gears	Both Hands	Speed	Wide/Short
		Traffic Ck	Correct Ln	Signal	Accel	Right
		Stop ? [ ]	Necessary	Gap	Stop Line	Full Stop
5. UP GRADE		Proper Gear	Keep Right	4-ways, slow	Traffic Ck	
6. DOWN GRADE		Proper Gear	Brake	Clutch	Steady Spd	Traffic Ck
7. START/STOP ON GRADE						
Approach, Stop, Resume		Traffic Ck	Signal On	Correct Ln	Decel	Not Coast
		Parallel	Not roll	Cancel Sigl	4-Ways On	Pkg Brake
		Traffic Ck	4 Ways-Off	Signal	Pkg Brake	Not Stall
		Traffic Ck	Accel			
8. RURAL/URBAN		Traffic Ck	Prop Lane	Keeps/Lane	Follow Dist	Speed
Lane Change	Lane? [ ]	Traffic Ck	Signal	Spacing	Smooth Chg	Cancel Sig
9. STOPPED INTERSECTION						
Stopping		Traffic Ck	Coast	Decel	Stop/Line	Gap
Drvg Thru		Full Stop				
		Traffic Ck	Yield	Correct Lane	Gear Change	Accel
10. GENERAL DRIVING BEHAVIOR		Clutch Accident	Brakes Sign/Sigl	Gears	Steering	

## SCORING ROAD TEST

An applicant "fails" if the number of points circled in Column C exceeds the number of errors allowed. To determine the number of errors allowed, count the number of checks in Column B, then refer to the Error Table. Applicants who exceed the number of errors allowed are given a fail.

"B" P S  
NOAIR 6874

## ERROR TABLE

Column B Checks	# Errors Allowed
5	27
4	26
3	25
2	24
1	23
0	22

Comments:

Immediate Fail:

SCORE:

PASS [ ]

FAIL [ ]

Applicant Signature:

Safety Specialist Signature:

ID #:

3567

CDL-12 (R9/03)

Class

B

Bus Endorsement (P.Q.R)

16+

GVWR

24800

Upgrade

Y

N

License Plate #

CIV 123



128784922

EXAMINATION PERMIT

JOHN M TIEMAN

CDL *B*

CLASS: A COMMERCIAL  
ENDR: T DBL/TRPL  
N TANK  
P PASSENGER  
S SCHOOL BUS



CERTIFICATE NOT ISSUED

MC MH201124200000030

DOB:  
ISSUED: 08/30/2011  
HT: 6-02  
FEE: 125.00 (K)

RESTR: L AIR BRAKES  
EXPIRES: 02/26/2012  
EYES: HAZ SEX: M  
MC MH20112420030  
ADD

NOT VALID FOR PRACTICE  
DRIVING UNTIL OFFICIALLY  
STAMPED ON REVERSE SIDE

128784922

ROAD TEST NO

ID APPROVAL

CS *ADDL* NO *5537*

REJECTED BY RETURN

*ADM/SSP*  
*35/11* OCT 12 2011

LAW

SIGN DATE

VISION

WOG R20 L20 B20

WG R20 *1/4/20/1/4* B20

CP *OK* BY *5537* DATE *5537*

RESTRICTIONS

DRIVING *3537* DATE *1-26-12*  
*Bone*



*(X)*

*Chg Restriction To 1*  
Validation

KNOWLEDGE TEST  
AUTO

BASIC KNOW

COMBO VEH

AIR BRAKES

DBL/TRPL

HAZ MAT

TANKER

PASSENGER

SCHOOL BUS

MOTORCYCLE

*70749*  
*1/4/20* OCT 13 2011

*PASS* OCT 24 2011  
*PASS* NOV 01 2011

ID REQUIRED FOR ROAD TEST

APPOINTMENT FOR DRIVING TEST  
DATE TIME ACTUAL

*1-26-12 8AM*

EXAMINATION PERMIT

**CDL**

JOHN M TIEMAN

CLASS: A COMMERCIAL  
ENDR: T DBL/TRPL  
N TANK  
P PASSENGER  
S, SCHOOL BUS



**CERTIFICATE NOT ISSUED**

DOB:  
ISSUED: 08/30/2011  
HT: 6-02  
FEE: 125.00 (K)

RESTR:L AIR BRAKES  
EXPIRES: 02/26/2012  
EYES: HAZ SEX: M  
MC MH20112420030  
ADD

MC MH201124200000030

NOT VALID FOR PRACTICE  
DRIVING UNTIL OFFICIALLY  
STAMPED ON REVERSE SIDE

128784922

ROAD TEST NO  
ID APPROVAL  
CS WDDL NO 5337

REJECTED BY RETURN

REJECTED BY  
-ADM/SSP  
35/11 OCT 12 2011

LAW  
SIGN                      DATE

## VISION

WOG R20 L20 B20  
WG R20 L20 B20  
CP BY 5537 DATE 5537

RESTRICTIONS

DRIVING DATE

X

Chg Restriction To I Validation

KNOWLEDGE	EST	10/1/99
AUTO	#1488	
BASIC KNOW	1/83	OCT 13 2011
COMBO VEH		
AIR BRAKES		
DBL/TRPL		
HAZ MAT		
TANKER		
PASSENGER	1/83	OCT 24 2011
SCHOOL BUS	1/83	NOV 01 2011
MOTORCYCLE		

**MOTORCYCLE**

**ID REQUIRED**

**APPOINTMENT FOR DRIVING TEST**

DATE TIME ACTUAL

DATE 01/1 TIME 12/28/11 ACTUAL 10

x

128784922

EXAMINATION PERMIT

CDL

JOHN M TIEMAN

CLASS A COMMERCIAL  
 ENDR: T DBL/TRPL  
 N TANK  
 P PASSENGER  
 S SCHOOL BUS



CERTIFICATE NOT ISSUED

DOB: EXPIRES: 02/26/2012  
 ISSUED: 08/30/2011 EYES: HAZ SEX: M  
 HT: 6-02 MC MH20112420030  
 FEE: 125.00 (K) ADD

MC MH201124200000030

NOT VALID FOR PRACTICE  
 DRIVING UNTIL OFFICIALLY  
 STAMPED ON REVERSE SIDE

(X)

128784922

ROAD TEST NO  
 ID APPROVAL

CS \_\_\_\_\_ NO \_\_\_\_\_

REJECTED BY

-ATM/SSP

RETURN

KNOWLEDGE TEST:

AUTO

BASIC KNOW

COMBO VEH

AIR BRAKES

DBL/TRPL

HAZ MAT

TANKER

PASSENGER

SCHOOL BUS

MOTORCYCLE

LAW

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

VISION

WOG R20 L20 B20

WG R20 L20 B20

CP \_\_\_\_\_ BY \_\_\_\_\_ DATE \_\_\_\_\_

APPOINTMENT FOR DRIVING TEST

PLACE DATE TIME ACTUAL

RESTRICTIONS \_\_\_\_\_

DRIVING \_\_\_\_\_ DATE \_\_\_\_\_

X \_\_\_\_\_

Virtua At Work Westampton  
**EMPLOYER DRUG TESTING SUMMARY REPORT**  
Reported as of 2/09/12

To: Peter Brunt  
GST Transport  
1897 Route 38  
Southampton, NJ 08088

**Confidential**

**Drug Test Collection Information**

Employee: John M Tieman

Identity:

Address:

Dept Unit:

Job Class:

Collection Date:	2/06/2012	CCF#: 2010868068
Collection Protocol:	Federal	
Collector:	Merenda, Sandra	
Notified Date:		
Drug Test Profile:	DOT Urine Drug Screen	
Laboratory:	CRL Clinical Reference Laboratory 8433 Quivira Road Shawnee Mission KS 66215	
Drug Test Reason:	Pre-Placement	

**Drug Test Results Information**

Substance	Result
Amphetamines	Negative
Cocaine	Negative
Marijuana-Cannabinoids	Negative
Opiates	Negative
Phencyclidine-PCP	Negative
Ecstasy	Negative

**Evaluation**

**FINAL TEST DETERMINATION:** Negative

**COMMENT:**

MRO: Eskin, Evamaria MD

MRO Request Date:

Results Reported By: Eskin, Evamaria MD

**VIRTUA MEMORIAL**  
175 MADISON AVE MOUNT HOLLY, NJ 08060  
DEPARTMENT OF RADIOLOGY

Name: **TIEMAN, JOHN M**  
Patient Address: 1475 MT HOLLY ROAD APT C8  
BEVERLY, NJ 08010

Folder Number:	000000487639	Med Rec #:	
Admission #:	004015807094	Admit Date:	02/06/12
Date of Birth:	Age: 66Y	Class:	O
Patient Phone:		Hosp Service:	AAW
Ordered By:	EVANS, II, NATHANIEL R. M.D.		

**\*\*\*Final Report\*\*\***

**PROCEDURE: ADX 1020 - CHEST ROUTINE 2 VIEW**  
**ORDERING CLINICIAN: EVANS, II, NATHANIEL R. M.D.**

**DATE OF EXAM: Feb 6 2012 11:38AM**      **RIS ORDER NO: 90001**      **ACC. #:**  
**CPT: 71020**

**HISTORY: Positive PPD.**

**TECHNIQUE: Two views of the chest were obtained.**

**FINDINGS: Prior radiographs from Larchmont Imaging Associates including thoracic spine study from 6/17/2008 and a more recent chest x-ray dated 7/28/11.**

The study is somewhat limited due to technique. Sternal wires and coronary artery markers are present. The lungs are clear. The vasculature is normal. The cardiac silhouette is mildly enlarged. The mediastinum and hila are unremarkable. An old right posterior eighth rib fracture is again evident. Degenerative changes are present in the thoracic spine. Portions of the anterior lower chest is not fully included on the lateral view.

**IMPRESSION: The study is somewhat limited due to technique. No active cardiopulmonary disease is evident.**

**Transcriptionist: ET**  
**Dictated Date: Feb 6 2012**  
**Transcribe Date/Time: Feb 6 2012 4:34P**  
**Read By: KEVIN P. BARRY M.D.**  
**Signed By: KEVIN P. BARRY M.D.**

**PROFESSIONAL CODES: 71020**

**END OF REPORT**

**VIRTUA HEALTH**

Employee Health &amp; Safety

1200 Howard Blvd.

Mt. Laurel, NJ 08054

Fax (856) 762-2760

Phone (856) 761-3862

**TUBERCULOSIS EVALUATION - (Positive Mantoux Test)**☐ Initial☐ Annual☐ Semi-Annual☐ Exposure☐ Berlin☐ Camden☐ Marlton☐ Memorial☐ Voorhees☐ \_\_\_\_\_**PLEASE PRINT:**Name: JOHN M. TIEMAN

DOB: \_\_\_\_\_

Department: \_\_\_\_\_

ID#: \_\_\_\_\_

**IN THE PAST THREE WEEKS HAVE YOU HAD:**

	ONSET DATE		ONSET DATE
( ) Cough		( ) Night Sweats	
( ) Weight Loss		( ) Wheezing	
( ) Fever		( ) Sputum Production (Expectoration)	
( ) Shortness of Breath (Dyspnea)		( ) Loss of Appetite	
( ) Swollen Glands		( ) Coughing Blood (Hemoptysis)	
( ) Hoarseness		( ) No Complaint	
( ) Other - Specify			

Date of Last Chest X-Ray: APRIL 2011

Recommendation of follow-up:

☐ None.☐ Referred to Occupational Health for evaluation/follow-up.☒ Evaluated by Occupational Health; given Prescription for Chest X-ray.☐ Other: \_\_\_\_\_

LIVELY URINARY TB

**EMPLOYEE:**

I acknowledge that I have been counseled regarding the signs of possible TB infection. By my signature below, I am verifying my understanding of the counseling and recommendations I have received. I have been instructed to report any signs and symptoms of possible TB infection to Occupational Health Services.

\_\_\_\_\_  
Employee Signature2-6-12  
Date\_\_\_\_\_  
Provider Signature2-6-12  
Date

(22)



## AUTHORIZATION FOR SERVICES

Please call in advance to schedule an appointment for service.

Employee Name: John Tieman

Position being Considered for/Employee's Position: School Bus Driver

Company Name: **GST TRANSPORT**

Services/Treatment authorized by:

(Authorized Signature)

Kathleen S. Becker / Manager

(Printed Name & Title)

Date/Time of Authorization: Monday, February 6, 2012

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*Please provide services as indicated:**

- ( ) DOT Physical (Please Indicate: \_\_\_ Pre-Employment \_\_\_ Recertification)  
( ) DOT Urine Drug Screen (Please Indicate: \_\_\_ Pre-Employment \_\_\_ Random)  
( ) Breath Alcohol Test  
( ) PPD  
( ) Non-DOT (5-Panel) UDS with COC (Please Indicate: \_\_\_ Pre-Employment \_\_\_ Recertification)  
( ) Workers Compensation (please indicate below if post accident drug/alcohol testing required)  
( ) Post Accident \_\_\_ DOT UDS \_\_\_ Non-DOT UDS (with COC)  
( ) Post Accident Breath Alcohol Test

~~X~~ Other Services as Indicated: Chest X-ray, Past positive PPD

**For Injuries after normal business hours** please report to a Virtua Health Emergency Room and present this form to the registrar. Operator is to page Virtua at Work On-Call Technician if post accident drug/alcohol testing is required

895 Rancocas Road,  
Suite 1  
Westampton, NJ 08060  
(P) 609-914-8610  
(F) 609-914-8626

2309 Evesham Road,  
Suite 104  
Voorhees, NJ 08043  
(P) 856-325-5310  
(F) 856-325-5312

1000 Atlantic Avenue  
Camden, NJ 08104  
(P) 856-246-3542  
(F) 856-246-3528

239 Hurffville-Crosskeys Road,  
Suite 160  
Sewell, NJ 08080  
(P) 856-341-8200  
(F) 856-341-8215



## AUTHORIZATION FOR SERVICES

Please call in advance to schedule an appointment for service.

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Position being Considered for/Employee's Position: School Bus Driver

Company Name: GST TRANSPORT

Services/Treatment authorized by: \_\_\_\_\_  
(Authorized Signature)

Kathleen S. Becker / Manager  
(Printed Name & Title)

Date/Time of Authorization: Monday, February 6, 2012

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

\*Please provide services as indicated:

( ) DOT Physical (Please Indicate: Pre-Employment Recertification)

~~( )~~ DOT Urine Drug Screen (Please Indicate: ~~Pre-Employment~~ Random)

( ) Breath Alcohol Test

~~( )~~ PPD

( ) Non-DOT (5-Panel) UDS with COC (Please Indicate: Pre-Employment Recertification)

( ) Workers Compensation (please indicate below if post accident drug/alcohol testing required)

( ) Post Accident DOT UDS Non-DOT UDS (with COC)

( ) Post Accident Breath Alcohol Test

( ) Other Services as Indicated: \_\_\_\_\_

**For Injuries after normal business hours please report to a Virtua Health Emergency Room and present this form to the registrar. Operator is to page Virtua at Work On-Call Technician if post accident drug/alcohol testing is required**

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239 Hurffville-Crosskeys Road,  
Suite 160  
Sewell, NJ 08080  
(P) 856-341-8200  
(F) 856-341-8215



# MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined John Tieman in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of his/her duties, I find this person to be qualified; and, if applicable, only when:

- ☒ wearing corrective lenses
- ☐ driving within an exempt intracity zone (49 CFR 391.62)
- ☐ wearing hearing aid
- ☐ accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ accompanied by a \_\_\_\_\_ waiver/exemption
- ☐ qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

TELEPHONE _____		DATE <u>1-10-12</u>
MEDICAL EXAMINER'S NAME (PRINT) <u>Dr. Bill Stefanou</u>		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Physician Assistant <input checked="" type="checkbox"/> Chiropractor <input type="checkbox"/> Advanced Practice Nurse
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. / ISSUING STATE <u>38MCO2228700/17</u>		
SIGNATURE OF DRIVER <u>[Signature]</u>	DRIVER'S LICENSE NO. _____	STATE _____
ADDRESS _____		
MEDICAL CERTIFICATE EXPIRATION DATE <u>1/10/2013</u>		

MOTOR CARRIER COPY

SEPARATE MOTOR CARRIER COPY BEFORE REMOVING LINER FROM LAMINATE

# **Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION**

649-F (6045)

## **1. DRIVER'S INFORMATION**

Driver completes this section

Driver's Name (Last, First, Middle) <b>TIEMAN JOHN MICHAEL</b>		Social Security No.	Birthdate MM/DD/YY	Age <b>66</b>	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	New Certification <input checked="" type="checkbox"/> Recertification <input type="checkbox"/> Follow-up <input type="checkbox"/>	Date of Exam <b>1-10-12</b>
Address		City, State, Zip Code	Work Tel: ( )	Driver License No.		License Class <input type="checkbox"/> A <input type="checkbox"/> C <input checked="" type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> Other	State of Issue <b>NJ</b>
			Home Tel:				

## **2. HEALTH HISTORY**

Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes	No		Yes	No		Yes	No	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Any illness or injury in the last 5 years?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Fainting, dizziness
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Head/Brain injuries, disorders or illnesses	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney disease, dialysis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Seizures, epilepsy <input type="checkbox"/> medication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stroke or paralysis
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Missing or impaired hand, arm, foot, leg, finger, toe
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Ear disorders, loss of hearing or balance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> diet <input type="checkbox"/> pills <input type="checkbox"/> insulin	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack; other cardiovascular condition <input checked="" type="checkbox"/> medication <b>TOPORAL XL</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders, e.g., <b>MILD</b> severe depression medication <b>CLONAZEPAM</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Chronic low back pain
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Heart surgery (valve repair, bypass, angioplasty, pacemaker)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Loss of, or altered consciousness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use
<input type="checkbox"/>	<input checked="" type="checkbox"/>	High blood pressure <input type="checkbox"/> medication				<input type="checkbox"/>	<input checked="" type="checkbox"/>	Narcotic or habit forming drug use
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Muscular disease						
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Shortness of breath						

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

9-28-10 HEART OPERATION VALVE REPAIR, 2 BYPASSES DR. CONN 7 YRS 9-11 DR. REIGAN 92, 04, 04  
2 GLASSES OF WINE PER DAY 20mg 1/DAY SIMVASTATIN 40 1/DAY, NEXIUM 40 MG 2/DAY  
CLONAZEPAM 1mg 2/DAY CITALOPRAM 20mg 1/DAY

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature \_\_\_\_\_

Date **1-10-12**

**Medical Examiner's Comments on Health History** (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

**DISCUSSED ABOVE AND DOES NOT INTERFERE  
W/ DRIVING. B.S.**

**TESTING (Medical Examiner completes Section 3 through 7)** Name: Last, Tiemon First, John Middle, \_\_\_\_\_

**3. VISION** Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

**INSTRUCTIONS:** When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. **Monocular drivers are not qualified.**

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/ 100	20/ 30	Right Eye 100 °
Left Eye	20/ 100	20/ 30	Left Eye 100 °
Both Eyes	20/ 70	20/ 25	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? ☒ Yes ☐ No

Applicant meets visual acuity requirement only when wearing: ☒ Corrective Lenses

Monocular Vision: ☐ Yes ☒ No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination \_\_\_\_\_ Name of Ophthalmologist or Optometrist (print) \_\_\_\_\_ Tel. No. \_\_\_\_\_ License No./ State of Issue \_\_\_\_\_ Signature \_\_\_\_\_

**4. HEARING** Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB ☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

**INSTRUCTIONS:** To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear 6 Feet	Left Ear 6 Feet
--	------------------	-----------------

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Average:			Average:		

**5. BLOOD PRESSURE/ PULSE RATE** Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure: Systolic 145 Diastolic 80

Driver qualified if ≤140/90.

Pulse Rate: ☒ Regular ☐ Irregular

Record Pulse Rate: 76

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if ≤140/90. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if ≤140/90
≥180/110	Stage 3	6 months from date of exam if ≤140/90	6 months if ≤ 140/90

**6. LABORATORY AND OTHER TEST FINDINGS** Numerical readings must be recorded.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other Testing (Describe and record) \_\_\_\_\_

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR
<u>1.014</u>	<u>uf</u>	<u>uf</u>	<u>uf</u>	<u>uf</u>

# 7. PHYSICAL EXAMINATION

Height: 6'1" (in.) Weight: 216 (lbs.)

Name: Last, Tieman First, John Middle,

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See Instructions to the Medical Examiner for guidance.

BODY SYSTEM	CHECK FOR:	YES*	NO	BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.			7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruises, hernia, significant abdominal wall muscle weakness.		
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate.			8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.			9. Genito-urinary System	Hernias.		
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.			10. Extremities- Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.	Loss or impairment of leg, foot, toe, arm, hand, finger, Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.			11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/ or xray of chest.			12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.		

## \*COMMENTS:

Note certification status here. See Instructions to the Medical Examiner for guidance.

☒ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate

☐ Does not meet standards

☒ Meets standards, but periodic monitoring required due to HIGH B.P.  
Driver qualified only for: ☐ 3 months ☐ 6 months ☒ 1 year ☐ Other

Temporarily disqualified due to (condition or medication): \_\_\_\_\_

Return to medical examiner's office for follow up on \_\_\_\_\_

☒ Wearing corrective lense

☐ Wearing hearing aid

☐ Accompanied by a \_\_\_\_\_ waiver/ exemption. Driver must present exemption at time of certification.

☐ Skill Performance Evaluation (SPE) Certificate

☐ Driving within an exempt intracity

☐ Qualified by operation of 49 CFR

Medical Examiner's signature \_\_\_\_\_

Medical Examiner's name DR. BILL E. STEFANO

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

If meets standards, complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h). (Driver must carry certificate when operating a commercial vehicle.)

## CJIS 2000 Response

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### DMV Response

02/17/2012 07:57:53  
1L01  
NJ00307A1

MKE/NJ DMV RESPONSE

OLN/

NAM/TIEMAN, JOHN M  
OLN EXP/10-31-2013 VEH CLASS/B  
DOB/ SEX/MALE EYE/HAZEL HGT/6-01 WGT/201 - 220  
SSN/ AGE/ 66 TOTAL POINTS/000 PHOTO/DIGITAL PHOTO LICENSE

#### ENDORSEMENTS/RESTRICTIONS:

NUM OF ENDORSEMENTS FOUND: 02

P. PASSENGER

STATUS/ACTIVE

S. SCHOOL BUS

STATUS/ACTIVE

NUM OF RESTRICTIONS FOUND: 04

L. EXCEPT VEH W/AIR BRAKES

STATUS/ACTIVE

N. NO CLASS A OR B PASS VEH

STATUS/REMOVED

Q. PASSENGER 15 OR LESS ONLY

STATUS/REMOVED

1. CORRECTIVE LENSES REQD

STATUS/ACTIVE

**NAM:TIEMAN, JOHN M DOB:**