

K3 Directional Drilling, Inc.
Employment Application Checklist
Year 2023

Name _____

Phone Number _____

Email Address _____

A	Drivers License - need copy (Scan copy)		
B	Social Security Card - need copy		
C	Passport Or Permanent Resident Card		
D	CDL Medical Card (if Applicable)		
E	Safety Performance History Records Request	1, 2	Y MVR
F	W-4 Form	3, 4	AA E-Verify
G	Form (Employment Eligibility Verification)	5, 6, 7	BB FL - New Hire form
H	Direct Deposit Form (or copy of check)	8	CC Auto Insurance Policy
I	Driving Policy	9	DD Wex System
J	Application	10, 11	EE Insurance (after 60 days)
K	Work & Conduct Rules	12	FF Pay Rate Sheet (excel)
L	Policy Against Harassment	13, 14	GG Driver List (excel)
M	Family & Medical Leave Policy	15, 16	HH PNC Credit Card (if applicable)
N	Payroll Policy	17	JJ Home Depot Credit Card
O	Acknowledgments	18, 19	
P	Medical Questionnaire	20, 21, 22, 23	
Q	Employee Responsibilities	24	
R	Personal Protection Equipment List	25	
S	Safety Check List	26	
T	Sick / Late Protocol, Time Off/Vacation, The, Driving Policy	27, 28	
U	Driving Information Green Farms Lane	29	
V	Credit Card Holders Agenda, Hotel Receipts	30	
W	BCBS Enrollment forms	31A, 32A	
X	Drug Testing Form		

PREVIOUS EMPLOYER – COMPLETE PAGE 2 PART 3

PART 3:	TO BE COMPLETED BY PREVIOUS EMPLOYER
DRUG AND ALCOHOL HISTORY	
<p>If driver was not subject to Department of Transportation testing requirements while employed by this employer, please check here <input type="checkbox"/>, fill in the dates of employment from _____ to _____, complete bottom of Part 3, sign, and return.</p> <p>Driver was subject to Department of Transportation testing requirements from _____ to _____.</p>	
<ol style="list-style-type: none"> 1. Has this person had an alcohol test with the result of 0.04 or higher alcohol concentration? YES <input type="checkbox"/> NO <input type="checkbox"/> 2. Has this person tested positive or adulterated or substituted a test specimen for controlled substances? YES <input type="checkbox"/> NO <input type="checkbox"/> 3. Has this person refused to submit to a post-accident, random, reasonable suspicion, or follow-up alcohol or controlled substance test? YES <input type="checkbox"/> NO <input type="checkbox"/> 4. Has this person committed other violations of Subpart B of Part 382, or Part 40? YES <input type="checkbox"/> NO <input type="checkbox"/> 5. If this person has violated a DOT drug and alcohol regulation, did this person complete a SAP-prescribed rehabilitation program in your employ, including return-to-duty and follow-up tests? If yes, please send documentation back with this form. YES <input type="checkbox"/> NO <input type="checkbox"/> 6. For a driver who successfully completed a SAP's rehabilitation referral and remained in your employ, did this driver subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refuse to be tested? YES <input type="checkbox"/> NO <input type="checkbox"/> 	
<p>In answering these questions, include any required DOT drug or alcohol testing information obtained from prior previous employers in the previous 3 years prior to the application date shown on page 1.</p>	
Name: _____	
Company: _____	
Street: _____	
City, State, Zip: _____ Telephone: _____	
Part 3 Completed by (Signature): _____ Date: _____	

PART 4a:	TO BE COMPLETED BY PROSPECTIVE EMPLOYER
<p>This form was (check one) <input type="checkbox"/> Faxed to previous employer <input type="checkbox"/> Mailed <input type="checkbox"/> Emailed <input type="checkbox"/> Other _____</p> <p>By: _____ Date: _____</p>	

PART 4b:	TO BE COMPLETED BY PROSPECTIVE EMPLOYER
<p>Complete below when information is obtained.</p> <p>Information received from: _____</p> <p>Recorded by: _____ Method: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Telephone</p> <p>Date: _____ <input type="checkbox"/> Other _____</p>	

INSTRUCTIONS TO COMPLETE THE SAFETY PERFORMANCE HISTORY RECORDS REQUEST

- PAGE 1 PART 1: Prospective Employee**
 - Complete the information required in this section
 - Sign and date
 - Submit to the Prospective Employer
- PAGE 2 PART 4a: Prospective Employer**
 - Complete the information
 - Send to Previous Employer
- PAGE 1 PART 2: Previous Employer**
 - Complete the information required in this section
 - Sign and date
 - Turn form over to complete SIDE 2 SECTION 3

- PAGE 2 PART 3: Previous Employer**
 - Complete the information required in this section
 - Sign and date
 - Return to Prospective Employer
- PAGE 2 PART 4b: Prospective Employer**
 - Record receipt of the information
 - Retain the form

Form W-4 (1999)

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 1999 expires February 16, 2000.

Note: You cannot claim exemption from withholding if (1) your income exceeds \$700 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. The worksheets on page 2 adjust your withholding allowances based on itemized

deductions, 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 allowances.

Child tax and higher education credits. For details on adjusting withholding for these and other credits, see Pub. 919, *Is My Withholding Correct for 1999?*

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.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, you should consider making estimated tax payments using Form 1040-ES. 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 will usually be most accurate when all allowances are claimed on the Form W-4 prepared for the highest paying job and zero allowances are claimed for 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 estimated total annual tax. Get Pub. 919 especially if you used the Two-Earner/Two-Job Worksheet 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

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. (This 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 F _____

G Child Tax Credit: • If your total income will be between \$20,000 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 amount may be different from the number of exemptions you claim on your 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 \$32,000, OR if you are married and have a working spouse or more than one job and the combined earnings from all jobs exceed \$55,000, 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 the certificate to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2>Employee's Withholding Allowance Certificate</h2> ▶ For Privacy Act and Paperwork Reduction Act Notice, see page 2.	OMB No. 1545-0010 1999
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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate <i>Note: If married, but legally separated or spouse is a nonresident alien, check the Single box.</i>
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 ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the worksheets on page 2 if they apply)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 1999, and I certify that I meet BOTH of the following conditions for exemption: <ul style="list-style-type: none"> • 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 8 and 10 only if sending to the IRS)		9 Office code (optional)
		10 Employer identification number

Cat. No. 1022CO

Deductions and Adjustments Worksheet

Note: Use this worksheet only if you plan to itemize deductions or claim adjustments to income on your 1999 tax return.

- 1 Enter an estimate of your 1999 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (but not sales taxes), medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 1999, you may have to reduce your itemized deductions if your income is over \$126,600 (\$63,300 if married filing separately). Get Pub. 919 for details.) 1 \$ _____
- 2 Enter: $\left\{ \begin{array}{l} \$7,200 \text{ if married filing jointly or qualifying widow(er)} \\ \$6,350 \text{ if head of household} \\ \$4,300 \text{ if single} \\ \$3,600 \text{ if married filing separately} \end{array} \right\}$ 2 \$ _____
- 3 Subtract line 2 from line 1. If line 2 is greater than line 1, enter -0- 3 \$ _____
- 4 Enter an estimate of your 1999 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 \$ _____
- 5 Add lines 3 and 4 and enter the total 5 \$ _____
- 6 Enter an estimate of your 1999 nonwage income (such as dividends or interest) 6 \$ _____
- 7 Subtract line 6 from line 5. Enter the result, but not less than -0- 7 \$ _____
- 8 Divide the amount on line 7 by \$3,000 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from Personal Allowances Worksheet, line H, on page 1 9 _____
- 10 Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earner/Two-Job Worksheet, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, on page 1 10 _____

Two-Earner/Two-Job Worksheet

Note: Use this worksheet only if the instructions for line H on page 1 direct you here.

- 1 Enter the number from line H on page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet) 1 _____
- 2 Find the number in Table 1 below that applies to the LOWEST paying job and enter it here 2 _____
- 3 If line 1 is GREATER THAN OR EQUAL TO line 2, subtract line 2 from line 1. Enter the result here (if zero, enter -0-) and on Form W-4, line 5, on page 1. DO NOT use the rest of this worksheet 3 _____

Note: If line 1 is LESS THAN line 2, enter -0- on Form W-4, line 5, on page 1. Complete lines 4-9 to calculate the additional withholding amount necessary to avoid a year end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 _____
- 5 Enter the number from line 1 of this worksheet 5 _____
- 6 Subtract line 5 from line 4 6 _____
- 7 Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here 7 \$ _____
- 8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding amount needed 8 \$ _____
- 9 Divide line 8 by the number of pay periods remaining in 1999. (For example, divide by 26 if you are paid every other week and you complete this form in December 1998.) Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1: Two-Earner/Two-Job Worksheet

Married Filing Jointly				All Others			
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above
\$0 - \$4,000	0	40,001 - 45,000	8	\$0 - \$5,000	0	65,001 - 80,000	8
4,001 - 7,000	1	45,001 - 54,000	9	5,001 - 11,000	1	80,001 - 100,000	9
7,001 - 12,000	2	54,001 - 62,000	10	11,001 - 16,000	2	100,001 and over	10
12,001 - 18,000	3	62,001 - 70,000	11	16,001 - 21,000	3		
18,001 - 24,000	4	70,001 - 85,000	12	21,001 - 25,000	4		
24,001 - 28,000	5	85,001 - 100,000	13	25,001 - 40,000	5		
28,001 - 35,000	6	100,001 - 110,000	14	40,001 - 50,000	6		
35,001 - 40,000	7	110,001 and over	15	50,001 - 65,000	7		

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$50,000	\$400	\$0 - \$30,000	\$400
50,001 - 100,000	770	30,001 - 60,000	770
100,001 - 130,000	850	60,001 - 120,000	850
130,001 - 240,000	1,000	120,001 - 250,000	1,000
240,001 and over	1,100	250,001 and over	1,100

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, and the District of Columbia for use in administering their tax laws.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or

records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is: Recordkeeping 46 min., Learning about the law or the form 10 min., Preparing the form 1 hr., 10 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. DO NOT send the tax form to this address. Instead, give it to your employer.





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **START HERE:** Read Instructions carefully before completing this form. The Instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address			Employee's Telephone Number

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 boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):

I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

Employer Completes Next Page



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification
(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write in This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative		
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name		
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

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	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
OR	AND	
1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	3. School ID card with a photograph	3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)	4. Voter's registration card	4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.	5. U.S. Military card or draft record	5. U.S. Citizen ID Card (Form I-197)
	6. Military dependent's ID card	6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	7. U.S. Coast Guard Merchant Mariner Card	7. Employment authorization document issued by the Department of Homeland Security
	8. Native American tribal document	
	9. Driver's license issued by a Canadian government authority	
	For persons under age 18 who are unable to present a document listed above:	
	10. School record or report card	
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

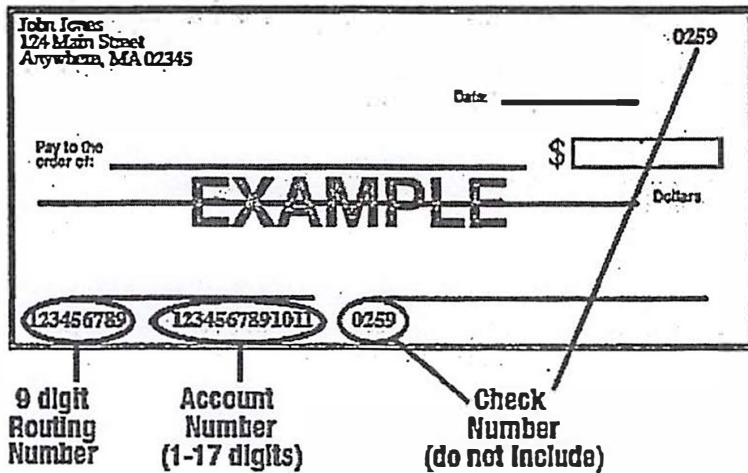
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: \$ _____ _____% or Entire Paycheck

Type of Account: Checking Savings (Circle One)

Please attach a voided check for each bank account to which funds should be deposited.

K3 Directional Drilling, Inc. is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

Driving Policy for K3 Directional Drilling Inc.

Objectives of the policy

- To ensure that staff who drive vehicles in the course of their work demonstrate safe, efficient driving skills and other good road safety habits at all times.
- To maintain all company vehicles in a safe, clean and roadworthy condition to ensure the maximum safety of the drivers, occupants and other road users.

Code of conduct

The code of conduct for K3 Directional Drilling states that: "While driving company vehicles, staff must comply with traffic legislation, be conscious of road safety and demonstrate safe driving and other good road safety habits".

The following actions in company vehicles will be viewed as serious breaches of conduct and dismissal may be a consequence:

- drinking or being under the influence of drugs while driving
- driving while disqualified or not correctly licensed
- reckless or dangerous driving causing death or injury
- failing to stop after a crash
- any actions that warrant the suspension of a licence.

Responsibilities as an employee

Every driver of a company vehicle will:

- no use of company vehicles for any personal reason unless written approval by management (Lewis Krantz)
- ensure they hold a current driver licence for the class of vehicle they are driving and this licence is carried when driving a company vehicle
- Immediately notify their supervisor or manager if their driver licence has been suspended or cancelled, or has had limitations placed upon it
- display the highest level of professional conduct when driving a company vehicle
- Regularly check the oil, tire pressures, radiator and battery levels of company vehicles
- comply with traffic legislation when driving
- Drive within the legal speed limits, including driving to the conditions
- wear a safety belt at all times
- Never drive under the influence of alcohol or drugs, including prescription and over the counter medication if they cause drowsiness – to do so will merit disciplinary measures
- avoid distraction when driving – the driver will adjust car stereos/mirrors etc before setting off, or pull over safely in order to do so
- report any near-hits, crashes and scrapes to their manager, including those that do not result in injury, and follow the crash procedures outlined in this policy
- report vehicle defects to a manager immediately
- forbidding the use of mobile phones in vehicles while driving, including ear buds

What employees are to do if there is a crash in a company vehicle

Immediately stop your vehicle at the scene or as close to it as possible, making sure you are not obstructing traffic. Ensure your own safety first. Help any injured people and call for assistance if needed.

Try to get the following information:

- contact your immediate supervisor (T.J. Mills and/or Lewis Krantz)
Give the following information:
- Your name and address and company details.

Employee Signature _____

Date _____

Application For Employment

We Are An Equal Opportunity Employer

Please Print

Last Name	First Name	Middle Initial	Social Security Number
Address	City	Zip Code	Phone Number

WORK EXPERIENCE - LIST MOST RECENT JOB FIRST

From	Employer's Name/Address/Telephone	Start Pay	Job Title
To		Last Pay	Reason for Leaving

Describe the Work You Did

From	Employer's Name/Address/Telephone	Start Pay	Job Title
To		Last Pay	Reason for Leaving

Describe the Work You Did

From	Employer's Name/Address/Telephone	Start Pay	Job Title
To		Last Pay	Reason for Leaving

Describe the Work You Did

GENERAL INFORMATION

What position are you applying for? _____ Full Time? Part Time?

When are you available to start work? _____ Are you willing to work overtime? Yes No

Are you at least 18 years old? Yes No

If not, can you provide a valid Work Permit, high school diploma, or equivalent? Yes No

What languages do you speak, read, or write fluently? _____

If hired, can you verify that you have the legal right to work in the United States? Yes No

Do you have any special skills, training, or experience which may help you qualify for this job? Yes No

If so, please explain _____

Do you have a reliable means of transportation to get to work? Yes No

Are there any times during the week that you are not available to work? Yes No

If so, please explain _____

Do any of your relatives work for this company? Yes No If so, who? _____

Have you ever worked for this company before? Yes No If so, when? _____

Have you ever been convicted of a crime, excluding misdemeanors and summary offenses? Yes No (NOTE: Conviction will not necessarily disqualify applicant)

If so, please explain _____

How did you find out about this job? _____

CERTIFICATION AND ACKNOWLEDGMENT

I certify that the information provided herein is true and correct to the best of my knowledge. I understand that, if employed, falsified statements on this Application for Employment form will be considered grounds for termination.

I authorize the company to thoroughly investigate my work experience and any other matters related to my suitability for employment. I further authorize my former employers to disclose to the company any and all information they may have concerning my previous employment. In addition, I hereby release the company, my former employers, and all other persons from any and all claims, demands, or liabilities arising out of, or in any way related to, such disclosure.

I acknowledge that, if employed, both the company and I have the right to terminate the employment relationship at any time, with or without cause or advance notice. This employment at will relationship will remain in effect throughout my employment with the company and may not be modified by any oral or implied agreement.

Applicant's Signature	Date
-----------------------	------

K3 DIRECTIONAL DRILLING INC.

Employment Application Part 2

Name: _____ Date of Birth: ____/____/____

Emergency Contacts

1. Name: _____ Relationship: _____
Phone number: _____

2. Name: _____ Relationship: _____
Phone number: _____

Optional: Completion of information below is strictly voluntary. K3 Directional Drilling Inc. is an equal opportunity employer. It is K3 Directional Drilling Inc. policy not to discriminate against any employee or applicant because of race, color, religion, sex, age, national origin, disability, or any other legally protected status. In an effort to comply with requirements regarding government record keeping, reporting and other legal obligations which may apply, we invited you to complete this applicant data survey below. Providing this information is STRICTLY VOLUNTARY. Failure to provide it will not subject you to any adverse personnel action. Please be advised that this survey is not part of our hiring decision. The information is kept confidential with all applicable laws and regulations.

Referral Source: (circle one)

Walk-in Current Employee, name: _____ Other: _____

Please check one of the following Equal Opportunity Identification Groups:

- _____ Caucasian - White
- _____ Hispanic or Latino
- _____ Black or African American
- _____ Pacific Islander
- _____ Other

Are you disabled? Yes No

Veteran of the U.S. Military? Yes No

National origin: USA Other

K3 DIRECTIONAL DRILLING INC.

Work & Conduct Rules

- Theft of company property or personal property could result in termination.
- Providing misleading information to obtain employment could result in your termination.
- Employees must contact supervisor immediately, if unable to report to work. If supervisor is unavailable, please contact the main office. Un-excused absenteeism is subject to termination.
- Our drug-free workplace policy states: K3 Directional Drilling Inc. prohibits the use, sale, distribution, manufacture or possession of alcohol, drugs or related paraphernalia or being under the influence of alcohol/drugs to the extent of impairment, while on company premises or worksites whether resulting from usage on or off job, unless prescribed by a licensed physician.
- Please note, if medicine prescribed from your licensed physician causes drowsiness, you are not allowed to operate vehicles or equipment.
- Unauthorized use of company vehicles, equipment or material is prohibited.
- Employees are required to report immediately any injury or accident involving themselves/employees/vehicles/equipment to the job supervisor; if unavailable, call the main office at 772-263-3002.
- Employees are required to wear appropriate clothing-Shirts (no tank tops), long pants (no shorts), and hard sole shoes (no sandals.)
- Firearms are not permitted in any company vehicles or on company grounds at any time.
- Disorderly conduct and/or horseplay on company premises will be subjected to disciplinary action.
- Employees are required to wear safety vests and hard hats at all times.
- Safety glasses are required when chipping, grinding, operating equipment or whenever an eye injury hazard exists. Safety glasses are available.
- Hearing protection should be worn when working around loud equipment. Earplugs are available.
- The following items of safety equipment are available: Safety vests, hard hats, ear plugs, safety glasses, rain gear and gloves.
- Each employee is responsible for protecting themselves against harmful UV rays.

Infraction of any of the above could result in disciplinary action and/or termination from the company.

I certify that I have read and understand the above rules.

Employee Signature

Date

K3 DIRECTIONAL DRILLING INC.

Policy against harassment

General policy:

K3 Directional Drilling Inc. (the "Company") is firmly committed to a work environment free from all forms of harassment based upon the protected status of any employee or applicant for employment by anyone, including management, supervisors, co-workers, clients or visitors. Such harassment violates both the Company Policy and state and federal discrimination laws. It is neither permitted nor condoned. This policy prohibits any verbal, physical or visual conduct that belittles or demeans an individual on the basis of race, color, religion, sex, national origin, age or disability.

Sexual harassment:

This policy specifically prohibits sexual harassment (including same sex harassment) as well as other forms of harassment. Sexual harassment includes any unwelcome sexual advances, requests for sexual favors, or other verbal/physical conduct of a sexual nature when:

The conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment.

Submission to such conduct is made either explicitly or implicitly as a term or condition of an individual's employment.

The individual's submission (or refusal) to such conduct is used or might be used as a basis for employment decisions (for example, promotion, transfer, salary recommendation or termination) affecting the individual.

Complaint Procedure:

Notification of Superiors

Any employee or applicant for employment who feels he or she has been harassed sexually or otherwise, or who knows of or suspects the occurrence of harassment, is strongly urged and encouraged to contact either his or her immediate supervisor, assistant superintendent, superintendent or project manager of the specific incident. If an employee feels uncomfortable approaching any of the above listed individuals the employee should contact any higher-level manager or officer of the company, including the President.

Investigating the Incident

All complaints will be handled in a timely and confidential manner. At no time will information concerning a complaint be released to third parties or to anyone in the Company who is not involved with the investigation, and no one involved in the investigation will be permitted to discuss the subject outside the investigation.

Disciplinary Action

If the investigation reveals that the complaint is valid, prompt attention and disciplinary action designed to stop the harassment immediately and to prevent a recurrence will be taken.

Records of Investigation

All investigations and complaints will be completely documented and will note the details of each investigation and the nature of any corrective action taken, or the lack of action with an explanation. Records

K3 DIRECTIONAL DRILLING INC.

Policy against harassment

will be kept confidential.

Non Retaliation

There will be no adverse action or discrimination taken against any individual filing a charge, testifying, assisting, or participating in any manner of investigation, proceeding or hearing under this policy.

Sexual harassment does not refer to behavior or occasional compliments of a socially acceptable nature. It refers to unwelcome behavior, which is personally offensive, that fails to respect the rights of others and, therefore, with work effectiveness. Sexual harassment may take different forms such as a demand for sexual favors, but there are other forms of harassment which include:

1. Verbal sexual innuendoes, suggestive comments, sexual proposition or jokes of a sexual nature.
2. Non-verbal sexually suggestive objects or pictures or obscene gestures.
3. Unwanted physical conduct of any kind.

The company recognizes that the question of whether or not a particular incident is of a purely personal, social nature, without a discriminatory employment effect, requires a factual determination of all evidence related to the matter. Given the nature of this type of discrimination, the Company recognizes that false accusations of sexual harassment, as well as other types of harassment, can have serious effects on innocent individuals. We trust that all personnel will continue to act responsibly to establish and maintain a working environment free of discrimination of any kind.

Acknowledgement of receipt of policy against sexual harassment

I HAVE RECEIVED A COPY OF K3 DIRECTIONAL DRILLING INC. POLICY AGAINST HARRASSMENT. I UNDERSTAND IT IS MY RESPONSIBILITY TO CAREFULLY READ IT AND BECOME FAMILIAR WITH ITS CONTENTS.

IF I HAVE ANY QUESTIONS OR CONCERNS RELATING TO THIS POLICY, I WILL BRING THEM TO THE ATTENTION OF MY IMMEDIATE SUPERVISOR OR OTHER HIGHER LEVEL SUPERVISOR OF THE COMPANY.

Employee Signature

Date

K3 DIRECTIONAL DRILLING INC.

Family & Medical Leave Policy

The Leave Policy- You are eligible to take up to 12 weeks of unpaid family/medical leave within any 12-month period and be restored to the same or equivalent position upon your return provided you:

- 1. Have worked for K3 Directional Drilling Inc. for at least 12 months and at least 1250 hours in the last 12 months.**
- 2. Are employed at a worksite that has 50 or more employees within a 75-mile radius.**

Reasons for Leave- You may take family/medical leave for any of the following reasons:

- 1. Birth of a son or daughter and to provide care for such.**
- 2. Placement of a son or daughter with you by adoption or foster care and to provide care for such.**
- 3. Care of a spouse, son, daughter or parent ("Covered relation") with a serious health condition.**
- 4. Serious personal health condition, which renders you unable to perform an essential function of your position.**

If leave is due to reason "1" or "2", or to care for a parent with a serious health condition, you may only take a combined total of 12 weeks during any 12-month period.

Notice of Leave -If your need for family/medical leave is foreseeable, you must give the Company at least 30 days written notice. If that is not possible, you must give notice as soon as practicable (within 1 to 2 business days of learning of your need for leave). Failure to provide such notice may be grounds for delay. Additionally, if you are planning medical treatment, you must first consult with the Company regarding the dates of such treatment. When the need for leave is not foreseeable, you are expected to notify the Company within 1 to 2 business days of learning of your need for leave, except in extraordinary circumstances. The Company has Request for Family/Medical leave forms available in the main office.

Medical Certification -If you are requesting leave because of your own or a covered relation's serious health condition, you and the relevant health care provider must supply appropriate medical certification. You may obtain medical certification forms from the main office. When you request leave, the Company will notify you of the requirement for medical certification and when it is due (at least 15 days after your request leave). If you provide at least 30 days notice of medical leave, you should also provide the medical certification before leave begins. Failure to provide requested medical certification, in a timely manner, might result in denial of leave until provided.

Reporting while on leave- If you take leave because of your own serious health condition or to care for a covered relation, you must contact the main office, on the first and third Tuesday of each month, regarding the status of the condition and your intention to return to work. In addition, you must give notice as soon as it is practical (within two business days) if the date of the leave are changed, extended, or were initially unknown.

Leave is Unpaid- Family medical leave is unpaid, though you may be eligible for short or long term disability and/or compensation benefits under insurance plans. If you request leave because of birth, adoption or foster care placement of a child, any paid vacation accumulated will be substituted for unpaid family/medical leave. If you request leave because of your own serious health condition or to care for a covered relation with a serious health condition, any paid vacation accumulated will be substituted for unpaid family/medical leave. The substitution of paid leave for unpaid leave will not extend beyond the 12-week period. In addition, in no case can the substitution of paid leave for unpaid leave result in receipt of more than 100 percent of your

K3 DIRECTIONAL DRILLING INC.

Family & Medical Leave Policy

salary. Your family/medical leave runs concurrently with other types of leave, i.e. paid vacation

Medical and other Benefits-During an approved family/medical leave, the Company will maintain your health benefits, as if you continue to be actively employed. If paid leave is substituted for unpaid leave, the Company will deduct your portion of the health plan premium as a regular payroll deduction. Health care coverage will terminate if your premium is more than 30 days late. If payment is more than 15 days late, you will receive a letter to this effect. If you elect not to return to work for at least 30 calendar days, at the end of the leave period, you will be required to reimburse the Company the cost of premiums paid during your unpaid leave, unless you cannot return to work because of a serious health condition or other circumstances beyond your control.

Exemption for Highly compensated Employees-Highly compensated employees (i.e. highest paid 10 percent of employees at a worksite or within a 75-mile radius of that worksite) may not be returned to their former or equivalent position following a leave if restoration of employment will cause substantial economic injury to the Company. The Company, on a case-by-case basis, will make this fact specific determination. The Company will notify you if you qualify as a "highly compensated" employee, if the Company intends to deny reinstatement, and of your rights in such instances.

Intermittent and Reduced Schedule Leave-Leave because of a serious health condition may be taken intermittently (in separate blocks of time due to a single health condition) or on a reduced leave schedule (reducing the usual number of hours you work per week, workweek or workday) if medically necessary. If leave is unpaid, the company will reduce your salary based on the amount of time actually worked. In addition, while you are on an intermittent or reduced schedule leave, the Company may temporarily transfer you to an available alternative position that better accommodates your recurring leave and which has equivalent pay and benefits.

Employee Signature

Date

K3 DIRECTIONAL DRILLING INC.

Payroll Policy

Payroll checks are given out on Friday of each week. Please note that there is a one week waiting period. If, for any reason, your employment terminates, your payroll check will be processed in the normal manner.

Your final paycheck will be held at the main office, unless otherwise directed.

If you would like your paycheck mailed or would like to have another individual pick up your check, you must write a letter with your signature giving K3 Directional Drilling Inc. permission to release your check.

If, for any reason, we need to place a stop payment on your paycheck and issue a new one, the stop payment fee of \$20.00 will be deducted from your next paycheck.

Please sign below that you have read this information and understand the content.

Employee Signature

Date:

K3 DIRECTIONAL DRILLING INC.

Acknowledgement

We consider applicants for all positions without regard to race, religion, gender, national origin, age, disability or any other legally protected status.

I understand that K3 Directional Drilling Inc., as part of the insurance process, will obtain consumer reports (e.g. driving records), containing certain information about me. By signing this application, I authorize the aforementioned parties to obtain such information.

I certify that I have read and understood all of this application and that the answers given herein are true and complete to the best of my knowledge. I also certify that I understand all employees of K3 Directional Drilling Inc. are "AT WILL" which means that an employee may resign at any time and that K3 Directional Drilling Inc. may terminate an employee at any time, for any reason, except as otherwise prohibited by law.

I hereby authorize investigation of all statements contained in this application and hereby release all former employers as a result of any statements they make concerning my employment with them. I understand that any misrepresentation or omission of facts called for in this application, in any attached supplement to the application, in any conditional offer questionnaire, or in any interview with K3 Directional Drilling Inc., Inc. are grounds for dismissal at any time, regardless of when the misrepresentation or omission is discovered.

I understand and agree that I may be requested by K3 Directional Drilling Inc. to take a drug and/or alcohol test in connection with my application for employment. I further understand that my failure or refusal to take such a test will result in the denial of my application for employment.

Employee Signature

Date

K3 DIRECTIONAL DRILLING INC.

Acknowledgement of Conditional Offer Terms

The Primary purpose of this questionnaire is to assist the company in determining whether, and to what extent a reasonable accommodation is required for a conditional job offered, to perform the essential functions of the job safely and effectively.

The conditional offeree is not an employee unless and until the conditional offer of employment is confirmed. The company may withdraw the conditional offer of employment at any time, for any reason, except as otherwise prohibited by law. This conditional offer and this questionnaire do not afford any express or implied contractual rights.

Failure to complete this questionnaire will result in the withdrawal of the conditional offer of employment.

I certify I have read and understand the job description and have been informed of the functions of the job for which I have applied. I certify that the statements are complete, accurate, and true to the best of my knowledge, and I understand that a falsified fact may be cause for withdraw or termination.

Employee Signature

Date

K3 DIRECTIONAL DRILLING INC.
Medical Questionnaire

This medical questionnaire should be completed only after an offer of employment has been made.
Please note that this questionnaire is kept separately in the personnel department.

Name: _____

1. Have you ever filed a Worker's Compensation claim or had any type of injury on the job?

Yes _____

No _____

If Yes, Date of claim: _____

Name of Employer: _____

Explain Injury and length of time out of work:

2. Please complete if you have had more than one Worker's Compensation claims or on-the-job injury:

Date of claim: _____

Name of Employer: _____

Explain Injury and length of time out of work:

3. Do you now use illegal drugs or controlled substances?

Yes _____

No _____

K3 DIRECTIONAL DRILLING INC.

Medical Questionnaire

If "Yes" please explain:

4. Do you wear glasses or contact lenses?

Yes _____

No _____

Please check one that applies:

Occasionally _____

All the time _____

Reading Only _____

5. Have you ever injured your back or neck?

Yes _____

No _____

If "Yes" please explain:

6. Do you have a disability, illness, condition, or disease? Please see definition of disability*:

Disability includes a physical or mental impairment that substantially limits one or more major life activities. Major life activities include such things as caring for oneself, performing manual tasks, walking, sitting, standing, lifting, reaching, seeing, hearing, breathing, learning and working.

Yes _____

No _____

If "Yes" please explain:

K3 DIRECTIONAL DRILLING INC.

Medical Questionnaire

If you answered "No" to question 6, do not answer question 7.

7. Are you able to perform your job duties "without" the need of Reasonable Accommodation by the Company? Please see definition of "Reasonable Accommodation"*

Reasonable Accommodation includes any modification to the job or work environment to enable a Conditional Offer to perform the essential functions of the job in question.

Yes _____

No _____

If "No" please explain the functions of the job that you are unable to perform without Reasonable Accommodation by the Company

If "No" please explain the Accommodations needed to perform the function of the job _____

List all treating physicians authorized to release medical records to confirm the functional limitations.

Name: _____

Address: _____

Name: _____

Address: _____

* The definitions are provided only as a guide for completing this form. Nothing in this questionnaire is intended to alter the legal definitions of these terms or impose obligations on the company that are not required by law.

K3 DIRECTIONAL DRILLING INC.

8. Have you ever had any of the following medical conditions?

Medical Condition	Yes	No	Medical Condition	Yes	No
<i>Epilepsy</i>			<i>Ulcers</i>		
<i>Diabetes</i>			<i>Head Injury</i>		
<i>Cardiac Disease</i>			<i>Cancer</i>		
<i>Polio</i>			<i>Dizziness or Fainting</i>		
<i>Cerebral Palsy</i>			<i>Arthritis</i>		
<i>Multiple Sclerosis</i>			<i>Knee Injury</i>		
<i>Parkinson's Disease</i>			<i>Hernia</i>		
<i>Muscular Dystrophy</i>			<i>AIDS</i>		
<i>Asthma</i>			<i>HIV Positive</i>		
<i>Total or Partial Deafness</i>			<i>Hepatitis</i>		
<i>Special Needs</i>			<i>Anker</i>		
<i>High Blood Pressure</i>			<i>Hemorrhoids</i>		
<i>Varicose Veins or leg Ulcer</i>			<i>Body Pain</i>		
<i>Chest Pain</i>			<i>Psychiatric Treatment</i>		
<i>Tuberculosis</i>					

If any medical conditions are checked "Yes" please give us a date and explain below:

Date: _____

Explanation: _____

Date: _____

Explanation: _____

K3 DIRECTIONAL DRILLING INC.

Employee Responsibilities

- Obey all safety rules, government regulations, signs, markings and instructions. Be particularly familiar with rules and regulations that apply directly to you in the area in which you work. If you don't know, ask your foreman.
- Report any condition or practice you think might cause injury and/or damage to equipment immediately to your supervisor.
- Always use the right tools and equipment for the job. Use them safely and only when authorized. If you are not familiar with the safe way to use a particular tool or piece of equipment, ask your supervisor. When using your own tools on the job, make sure all guards, ground pins, etc. are in place.
- All prescribed safety equipment and personal protective equipment must be used when required and must be maintained in good working condition. It is your personal responsibility to use such equipment. The use of required personal protective equipment is a non-negotiable item.
- Whenever you are involved in an accident that results in personal injury or property damage, no matter how slight, the accident must be reported to your supervisor or other management personnel prior to the end of the work shift. Get first aid promptly.
- Do not operate any equipment that, in your opinion, is not in a safe condition. Report immediately the condition that you believe is unsafe to your foreman.
- When lifting, use the appropriate lift technique (i.e., bend your knees, grasp load firmly, keep load close to you, then raise the load keeping your back as straight as possible. Always get help with heavy or awkward loads.
- Obey all rules and regulations in protecting the public.
- Do not engage in horseplay; avoid distracting others, be courteous to fellow workers.
- Good housekeeping must always be practiced. Return all tools, equipment, materials, etc. to their proper places when you are finished with them. Keep floors clean and passageways clear. Poor housekeeping wastes time, energy and material and often results in injury.
- The use of drugs and/or intoxicating beverages on the jobsite is forbidden. Being under the influence of alcohol or drugs when on the jobsite is inexcusable. Immediate discharge for being under the influence and/or using drugs or alcohol may be instituted.
- Being under the influence of alcohol or drugs when on the jobsite is inexcusable. Immediate discharge for being under the influence and/or using drugs or alcohol may be instituted.
- Appropriate disciplinary action will be taken for the following offenses:
 - Fighting
 - Insubordinate conduct or refusal to follow direction
 - False statement, such as injury claim
 - Other inappropriate behavior including, but not limited to, failure to obey safety rules.
 - Loose clothing or jewelry cannot be worn when operating machinery and equipment.
 - Proper work shoes shall be worn at all jobsites. Open toed shoes and sneakers are not permitted to be worn at any jobsite. If you are observed wearing open toes shoes or sneakers, you will not be permitted to work until you return with proper footwear.
 - Do not handle chemicals unless you have been trained in safe handling procedures.
 - Hard hats and eye protection shall be worn at all times.
 - Read, understand, and follow the guidelines set forth in the material safety data sheets (MSDS) pertaining to your work.
- Compliance with safety and health rules and regulations is a condition of employment.

K3 DIRECTIONAL DRILLING INC.

Employee Responsibilities

Employee Signature

Date

K3 DIRECTIONAL DRILLING INC.

Personal Protection Equipment List

The following items of personal safety equipment have been issued to me by K3 Directional Drilling Inc. I understand that this safety equipment is for my own personal use to be worn while on the job site and that I am responsible for keeping the equipment in good condition. I further understand that this safety equipment remains the property of K3 Directional Drilling Inc. and is to be returned to the company at the end of my employment:

- Safety Vests
- Hard Hat
- Safety Glasses
- Hearing Protection
- Gloves

I have read and understand the above.

Employee Signature

Date



1. Employee received Company Safety Program Information
2. Review:
 - Safety and Health Policy
 - Employee General Safety and Health Rules
 - Disciplinary Policy and Procedure
3. Instruct:
 - How to report unsafe conditions
 - What to do in the event of an injury on the job, and state when and where safety toolbox meetings occur
 - Hard hats, work boots, safety goggles are mandatory (Personal protective equipment is non-negotiable)
 - Fire Evacuation/Emergency Plan
 - Proper lifting techniques and importance of back fitness
 - OSHA Hazard Communication Policy and provide training
4. Other (please list)

I acknowledge that the information on the above subjects was furnished to me during my orientation and that I understand this information.

Employee Signature

Date



K3 DIRECTIONAL DRILLING INC.

8526 SW Kansas Ave, Stuart, FL 34997

Meeting Agenda

All Employee Meeting Agenda

Sick/Late Protocol

- If you are sick and have to miss work, YOU MUST communicate with your Direct Foreman, manager and Lewis before start of work time via phone call AND text.
- If you are late whether one minute or 30 minutes, YOU MUST ALSO communicate with your Direct Foreman, manager and Lewis immediately before start of work time via phone call AND text.

Time OFF/Vacation Time

- One full week of paid vacation after one full year of employment at owner's discretion.
- Vacation time cannot be rolled over or combined.
- Any vacation days left unused will be discounted.
- Vacation days MUST BE DISCUSSED AHEAD OF TIME allowing for adequate preparations. All vacation requests will be directed to Rick Amato in the office via email (rick@k3directionaldrilling.com)

Driving Policy

Responsibilities as an employee

Every driver of a company vehicle will comply with the following:

- no use of company vehicles for any personal reason unless written/ verbal approval by Lewis Krantz
- no drinking or being under the influence of drugs while driving

- no driving while disqualified or not correctly licensed
- no reckless or dangerous driving causing death or injury
- display the highest level of professional conduct when driving a company vehicle
- comply with traffic legislation when driving
- Drive within the legal speed limits, NO SPEEDING
- wear a safety belt at all times
- avoid distraction when driving – the driver will adjust car stereos/mirrors etc before setting off, or pull over safely in order to do so
- ABSOLUTELY NO SMOKING
 - the use of mobile phones in vehicles while driving, including ear buds is FORBIDDEN
 - No non-employee riders in company vehicles

Print Name _____

Employee Signature _____ **Date** _____



K3 DIRECTIONAL
DRILLING INC.

8526 SW Kansas Ave, Stuart, Florida 34997

Driving Infractions on Green Farms Lane

K3 Team,

It has been brought to the attention of ownership that the authorities have been notified on multiple occasions specifically for K3 employee. There has been blatant disregard for speed limits, stop signs and general traffic laws when driving out by the yard on Green Farms Lane.

From this point forward, any speeding, reckless driving, or running through stop signs, whether in your personal or in a K3 vehicle will lead to IMMEDIATE TERMINATION.

SIGNATURE X: _____



K3 DIRECTIONAL
DRILLING INC.

8526 SW Kansas Ave, Stuart, FL 34997

Credit Card Holders Agenda

- All credit card receipts **MUST** be turned in at week's end
- Any unaccounted for receipts will be subject to payroll deductions
- All credit card purchases for equipment or truck repairs must have PO prior to purchasing
- All purchases must have either a PO number, or job name AND number. Call Adam in the office if uncertain and you need a PO number or Job number supplied.
- All Home Depot purchases **MUST** use Lewis's email address for email receipts (lewis@k3directionaldrilling.com)

Hotel Receipts

- All hotel receipts **MUST** be collected upon checking out
- Each room receipt **MUST** have job name and number as well as the names of the employees who stayed in the room

X

Section F: Other Health Insurance Information *This section must be completed for claims processing* and Prior Coverage Information

In addition to this policy, do you or your dependents have any other insurance coverage (including Florida Blue and/or Truli for Health) that will be in effect after this coverage begins? Yes No

Florida Blue and/or Truli for Health Contract # _____ Medicare # _____ Pharmacy/Medicare D # _____

Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage.

Prior Health Carrier Name:		Contract #:	Effective Date:
Prior Employee Hire Date:	Cancel Date:	List names of all family members that were covered, including yourself:	
Signature:			Date:

Section G: Acceptance of Coverage

Plan Coverage Terms

I hereby apply for the coverage/membership that is selected on this form. My employer has selected health and/or vision coverage through Florida Blue and/or HMO coverage through Florida Blue HMO and/or Truli for Health.

I authorize my employer to deduct from my earnings my premium contribution, if any. I understand all of the following:

1. If my coverage/membership is to be issued and continued, I must meet all the group contract's requirements;
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all the group contract's requirements;
3. If I must pay part or all of the premium, coverage/membership shall not become effective until Florida Blue, Florida Blue HMO and/or Truli for Health accepts this application and assigns an effective date.

I understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contract.

I am aware that a change in coverage of dependents may affect the amount deducted from any wages (if any) for coverage/ membership, and I hereby authorize such a change.

If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize Florida Blue and/or Truli for Health to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

I understand that if I am enrolling in an HSA qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HSA compatible plan.

General Terms

I AGREE that in the event of any controversy or dispute between Florida Blue, Florida Blue HMO and/or Truli for Health, I and my dependents must exhaust the appeal and/or grievance processes in the benefit/member handbook issued to me.

I understand that my employer is not an agent of Florida Blue, Florida Blue HMO and/or Truli for Health. I also understand that my employer is responsible for notifying all employees of: 1. Effective dates; 2. All termination dates; 3. Any conversion, COBRA or ERISA rights or responsibilities; and 4. All other matters pertaining to coverage/membership under the group contract.

When an overpayment is made, I authorize Florida Blue and/or Florida Blue HMO and/or Truli for Health to recover the excess from any person or entity that received it.

I acknowledge that Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.

I represent that the statements on this application are true and complete to the best of my knowledge and belief.

I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature:	Date:
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Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. HMO coverage is offered by Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc., DBA Truli for Health. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.