EMPLOYEE DRUG / ALCOHOL CERTIFICATION AND CONSENT FORM

Applicant's Name: _____ *SSN:* _____

Vessel: _____ *Rating:* _____

Pursuant to US Dept of Transportation Regulation (DOT) 49CFR40.25, paragraph "J", you must respond truthfully to the following questions. During the past 24 mos., with respect to DOT/USCG pre-employment drug or alcohol testing, have you:

	Yes	No
• Had alcohol tests with a result of 0.04 or higher concentration?	☐	☐
• Had verified positive drug tests?	☐	☐
• Refused to test or had verified adulterated or substituted drug test results?	☐	☐
• Violated any other DOT/USCG drug and alcohol testing regulation?	☐	☐

With respect to any violation of the DOT/USCG chemical testing regulations, please provide documentation of your completion of DOT "return-to-duty" requirements including follow-up tests. **(Please attach documentation)**

If you answered YES to any of these questions, please provide our company with the following information:

Name of Substance Abuse Clinic/Professional: _____

Tel: _____ ***Fax:*** _____

I hereby authorize my previous employer(s) to release the following information with regard to my chemical testing records to my prospective employer.

Seaman's Signature: _____ *Date:* _____

List only DOT employers you have worked for during the past 24 months. If you worked for APL Maritime, Ltd. (AML) during the past 24 months, list only employers you worked for since you last worked for AML.

Previous DOT Employer: _____ ***Vessel:*** _____ ***Contact Person:*** _____

Tel No.: _____ ***Fax No.:*** _____ ***Employed From:*** ___/___/___ ***To:*** ___/___/___

Previous DOT Employer: _____ ***Vessel:*** _____ ***Contact Person:*** _____

Tel No.: _____ ***Fax No.:*** _____ ***Employed From:*** ___/___/___ ***To:*** ___/___/___

Previous DOT Employer: _____ ***Vessel:*** _____ ***Contact Person:*** _____

Tel No.: _____ ***Fax No.:*** _____ ***Employed From:*** ___/___/___ ***To:*** ___/___/___

TO BE COMPLETED ONLY BY PREVIOUS EMPLOYERS

	Yes	No
Had alcohol tests with a result of 0.04 or higher concentration?	☐	☐
Had verified positive drug tests?	☐	☐
Refused to test or had verified adulterated or substituted drug test results?	☐	☐
Violated any other DOT/USCG drug and alcohol testing regulation?	☐	☐

With respect to any violation of the DOT/USCG chemical testing regulations, please provide documentation of the applicant /employee's completion of DOT "return-to-duty" requirements, including follow-up tests.

Previous Employer: _____ Signature: _____ Date: ___/___/___

Please FAX the completed form to:

APL Maritime, Ltd
Marine Personnel

Fax: (301) 468-2752
Tel: (301) 468-7588

(301) 468-4297
(301) 468-7575

APL MARITIME, LTD

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.) ▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

123 Town Square Place #531 Jersey City, NJ 07310
TEL: 917-579-0257 FAX: 888-345-8335

New York • Athens • Manila • Beijing • Johannesburg

Authorization for Release of Medical Information

Patient Name: _____

Health Record #: _____ Date of Birth: _____

- I authorize the use of the above-named individual's health information as described below.
- This information may be disclosed to and used by the following individual or organization(s)

Organization(s): FUTURE CARE, INC / APL Maritime
Address: 123 Town Square Place #531, Jersey City, NJ 07310
For the purpose: Case Management/Managed Care Services

The following information is to be used or disclosed **for further continuation of care** (include dates where appropriate):

_____ Most recent History and Physical
_____ Most Recent Discharge Summary
_____ Problem List
_____ List of Allergies
_____ All Records On File

_____ Medication List
_____ Immunization Records
_____ Consultation Reports
_____ X-Rays, Imaging and Diagnostic Reports
__X__ COVID-19 testing records, results and related billing

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released to this authorization. I understand the revocation will NOT apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will continue until such time that FUTURE CARE, INC. is no longer providing services. I understand that the signing of this disclosure of health information is voluntary. I can refuse to sign this authorization and still receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524, and the information may be re-disclosed and therefore not protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Witnessed by

Special Request for Release:

I, _____, understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Witnessed by

APL

Pre COVID – 19 testing: SURVEY

SEAFARER INFORMATION			
Name		Nationality	
Birth date		City	
Ship name		Flag	
Departure port		Destination port	

SYMPTOMS, CLINICAL COURSE
During the last two weeks: **1.Where did you live or travel ?** COUNTRY/ STATE/ REGION _____ **2.Were you in contact with a person with high risk having COVID-19?** ☐ YES ☐ NO ☐ UNKNOWN If YES, specify COUNTRY/ STATE/ REGION_____
CONTACT with lab-confirmed COVID-19 case-patient? ☐ YES ☐ NO
CONTACT with suspected case-patient of COVID-19 ☐ YES ☐ NO
CONTACT with seafarer, worker or visitor of COVID-19 affected country ☐ YES ☐ NO

Current Vaccines

☐ Flu vaccines ☐ Pneumococcal vaccines ☐ No vaccines

22 January 2021

PREBOARDING SELF QUARANTINE INSTRUCTIONS

If Flying or Taking Public Transportation to Embarkation Port

1. After arrival at embarkation port take first COVID – 19 PCR Test.
    a. After test eight days of quarantine shall be observed.
    b. Remain in hotel room.
    c. No visits to public areas such as pools/gyms.
    d. No visitors to hotel. This includes other joining crew.

2. A second COVID – 19 PCR Test will be performed before seafarer's embarkation.

3. If the test result is negative, agent will arrange transport between seafarer's hotel or testing site and the vessel. Contacts with other people should be avoided during the transportation, and all preventive measures should be respected including barrier measures, distancing, and face covering.

4. Truthfully answer the COVID-19 Questionnaire prior to transiting to the vessel.

5. Should you have any questions please contact your Crewing Agent.

I agree to maintain quarantine as described above and to notify the company immediately in the event quarantine is broken for any reason.

Name _____ Signature _____ Date _____

DO YOU HAVE ANY of the following SYMPTOMS?

Appearance of symptoms date_____/___/_____

- ◻ Cough
- ◻ Sore throat
- ◻ Muscle aches
- ◻ Discomfort
- ◻ Anorexia
- ◻ Vomit or Diarrhea
- ◻ Headache
- ◻ Problem with smell or taste

Fever >100.4F (38°C): ◻ YES _____°F ◻ NO

HAVE YOU ALREADY HAD ANY TEST FOR COVID-19:

☐ YES ☐ NO Type of Test_____

If YES, specify PLACE and DATE:

DID YOU OBSERVE SELF QUARANTINE OF 8 DAYS AT HOME OR IN HOTEL:

☐ YES ☐ NO If YES, specify start date of quarantine:

BY YOUR SIGNATURE YOU ATTEST THAT DURING YOUR QUARANTAINE PERIOD YOU RESPECTED ALL PREVENTIVE MEASURES AGAINST COVID-19 INCLUDING BUT NOT LIMITED TO SOCIAL DISTANCING & BARRIER MEASURES,

AND YOU ACCEPT TO TAKE A COVID-19 DETECTION TEST AND TO COMMUNICATE THE RESULT (POSITIVE OR NEGATIVE) TO THE COMPANY.

DATE OF SIGNATURE: **PLACE OF SIGNATURE:**

NAME and SIGNATURE