

AVSOURCE AVIATION PROFESSIONALS, INC.
7430 U.S. HWY 42, SUITE 208
FLORENCE, KY 41042

Dear Applicant:

We are providing you with a complete SIGN-UP PACKET that you need to fill out completely in order for us to start the compliance and payroll process for you. Each page has its own specific instructions, so please, follow them precisely.

- A. The **Application information** needs to be carefully read and completed.
- B. The **Pre-Employment Urinalysis Notification Form** must be read and completed in its entirety.
- C. Clear and legible copies of your **ID's** are required for the **Employment Eligibility Verification / I-9 Form**. Please refer to the **List of Acceptable Documents** to see which type of identification qualifies. **ONLY Section 1 needs to be completed and signed.**
- D. Both **Federal and State Tax Forms** need to be filled out completely.
- E. The **Employment Certification of Per Diem** must be filled out completely and signed in order for us to verify your qualification for per diem rates. The permanent address listed on this form must be the same address listed on your tax forms.
- F. The **Direct Deposit Enrollment Form** needs to be filled out only if you are enrolling in Direct Deposit. Please provide a copy of a voided check with the routing and legible account number with the return of this document.
- G. To cancel Direct Deposit at any time, you must fill out the **Cancellation Form**. Direct Deposit will remain active until you complete and return this form to us.
- H. The **Receipt of Workers Compensation Information Card and Instruction** must be signed and dated. A **copy** of the card is located at the bottom of page 16. **Please keep a copy for your records.**
- I. Please **keep** the **Time Sheet** and the **O.J.T. Form** as a hard copy. These will need to be filled out on a weekly basis and faxed to this office. You may arrange with the On-Site Coordinator or the H.R. representative on the site.
- J. Instructions for **Background paperwork** is provided and must be correct and complete to qualify for employment with Avsource.

AFTER COMPLETION OF THESE REQUIRED DOCUMENTS, THEY MUST BE RETURNED TO AVSOURCE BY FAXING TO 859-282-8777, EMAIL TO recruiter@avsourceaviation.com OR YOU CAN MAIL THE COMPLETED START PACKET TO US AT THE ADDRESS LISTED ABOVE.

If you have any questions concerning any of these documents, please contact the Administrative Department at 606-425-3416.

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APPLICANT INFORMATION

Thank you for your interest in Avsource Aviation Professionals, Inc. In compliance with Federal Aviation Regulations, we are required to obtain the following information in order for the necessary background and/or criminal checks, license verification, employment checks, etc. to be conducted.

NAME: _____

Social Security #: _____ Date of Birth: * _____

***DOB optional (for use of criminal and driver's license record history. The Age Discrimination in Employment Act of 1967 prohibits discrimination in employment based on age.**

Driver's License #: _____ State of Issue: _____ Expiration Date: _____

A&P, FCC or other License#: _____ Type of License: _____

EMERGENCY

CONTACT INFO: _____

NAME

CONTACT #

RELATION

Are you legally eligible for work in the USA? _____ Are you 18 or Older? _____

Do you currently have unrestricted authorization to work in the USA? _____

Have you ever been convicted of, pleaded guilty to, or been found guilty of any misdemeanors or felonies listed on the page titled "Disqualifying Crimes"? _____

If YES, please explain: _____

1. This authorization and consent for release of personal information acknowledges that **AVSOURCE AVIATION PROFESSIONALS** and/or its agents may conduct investigations. In addition, I release and discharge the company and its agents and associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs, expenses or any other charge or complaint filed with any agency arising from retrieving and reporting this information.
2. I understand that, if employed, my employment will not be for any fixed period of time and may be terminated by **AVSOURCE AVIATION PROFESSIONALS** at any time.
3. I understand this notice will apply to any future update reports that may be requested. After reading this document, I fully understand its contents and authorize the verification of all the information I have provided. I hereby declare that all statement contained in the form are true and accurate and understand that false or inaccurate information in this form will be basis for termination.

EMPLOYEES SIGNATURE: _____ **DATE:** _____

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Disqualifying Crimes

In accordance with the FAA Regulations Part 1070.31, we are required to inform you of the crimes that would disqualify you from obtaining authority to have unescorted access privileges to the security identification display areas of an airport. Be sure you have never been convicted of one of these disqualifying crimes, prior to answering "no" on the background verification information.

- (i) Forgery of certificates, false marking of aircraft, and other aircraft registration violation
- (ii) Interference with air navigation
- (iii) Improper transportation of a hazardous material
- (iv) Aircraft piracy
- (v) Interference with flight crewmembers or flight attendants
- (vi) Commission of certain crimes aboard aircraft in flight
- (vii) Carrying a weapon or explosive aboard aircraft
- (viii) Conveying false information and threats
- (ix) Aircraft piracy outside the special aircraft jurisdiction of the United States
- (x) Lighting violations involving transporting controlled substances
- (xi) Unlawful entry into an aircraft or airport area that services air carriers or foreign air carriers contrary to established security requirements
- (xii) Destruction of an aircraft or aircraft facility
- (xiii) Murder
- (xiv) Assault with intent to murder
- (xv) Espionage
- (xvi) Sedition
- (xvii) Kidnapping or hostage taking
- (xviii) Treason
- (xix) Rape or aggravated sexual abuse
- (xx) Unlawful possession, use, sale, distribution, or manufacture of an explosive or weapon
- (xxi) Extortion
- (xxii) Armed robbery
- (xxiii) Distribution of, or intent to distribute a controlled substance
- (xxiv) Felony arson
- (xxv) Conspiracy or attempt to commit any of the aforementioned criminal acts



Acknowledgement of Drug Testing

I, _____, acknowledge that I will be pre-employment drug tested. The specific drugs I am being tested for are: Marijuana, Cocaine, Phencyclidine (PCP), Amphetamines and Opiates or a metabolite of these drugs.

Name: _____

Date: _____

Signature: _____

Revised 11/2011

7430 U.S. Hwy 42, Suite 208, Florence Kentucky 41042



Employee Drug and Alcohol Training

Statement of Completion Form

I, _____, have completed the required employee drug and alcohol training video for Avsource Aviation.

Name: _____

Date: _____

Signature: _____

Revised 11/2011

Suggested Format: "Release of Information Form -- 49 CFR Part 40 Drug and Alcohol Testing"

Section I. To be completed by the new employer, signed by the employee, and transmitted to the previous employer:

Employee Printed or Typed Name: _____

Employee SS or ID Number: _____

I hereby authorize release of information from my Department of Transportation regulated drug and alcohol testing records by my previous employer, listed in Section I-B, to the employer listed in Section I-A. This release is in accordance with DOT Regulation 49 CFR Part 40, Section 40.25. I understand that information to be released in Section II-A by my previous employer, is limited to the following DOT-regulated testing items:

1. Alcohol tests with a result of 0.04 or higher;
2. Verified positive drug tests;
3. Refusals to be tested;
4. Other violations of DOT agency drug and alcohol testing regulations;
5. Information obtained from previous employers of a drug and alcohol rule violation;
6. Documentation, if any, of completion of the return-to-duty process following a rule violation.

Employee Signature: _____ Date: _____

I-A.

New Employer Name: _____

Address: _____

Phone #: _____ Fax #: _____

Designated Employer Representative: _____

I-B.

Previous Employer Name: _____

Address: _____

Phone #: _____

Designated Employer Representative (if known): _____

Section II. To be completed by the previous employer and transmitted by mail or fax to the new employer:

II-A. In the two years prior to the date of the employee's signature (in Section I), for DOT-regulated testing ~

- | | |
|---|------------------------|
| 1. Did the employee have alcohol tests with a result of 0.04 or higher? | YES ___ NO ___ |
| 2. Did the employee have verified positive drug tests? | YES ___ NO ___ |
| 3. Did the employee refuse to be tested? | YES ___ NO ___ |
| 4. Did the employee have other violations of DOT agency drug and alcohol testing regulations? | YES ___ NO ___ |
| 5. Did a previous employer report a drug and alcohol rule violation to you? | YES ___ NO ___ |
| 6. If you answered "yes" to any of the above items, did the employee complete the return-to-duty process? | N/A ___ YES ___ NO ___ |

NOTE: If you answered "yes" to item 5, you must provide the previous employer's report. If you answered "yes" to item 6, you must also transmit the appropriate return-to-duty documentation (e.g., SAP report(s), follow-up testing record).

II-B.

Name of person providing information in Section II-A: _____

Title: _____

Phone #: _____

Date: _____

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WEEKLY TIME SHEET

COMPANY: _____ **LOCATION:** _____

WEEK ENDING: _____

DATE	DAY	TAIL NUMBER	IN	OUT	TOTAL TIME
	MON				
	TUE				
	WED				
	THU				
	FRI				
	SAT				
	SUN				
FAX COMPLETED TIME SHEET TO (859) 282-8777				TOTAL HOURS _____ STRAIGHT _____ OVERTIME _____	

EMPLOYEE: _____

(PRINT)

EMPLOYEE: _____

(SIGNATURE)

CLIENT (PLEASE PRINT AND SIGN)

Time sheets must be completed, signed and faxed to Avsource Aviation Professionals by 9AM EST Monday.

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**EMPLOYEE CERTIFICATION OF PER DIEM
SUBSTANTIATION REQUIREMENTS**

This certification is made for the purpose of receiving money in the form of per diem. As an Avsource Aviation Professionals, Inc. contract employee, I am aware that non-taxable per diem allowances must not exceed the FEDERAL PER DIEM rates with respect to necessary business expenses incurred for lodging, meals or incidental expenses for travel away from home as an employee on temporary assignment. Therefore, in consideration of my receipt of per diem allowances under an accountable plan,

I, _____
(Print Full Name)

Represent the following to Avsource Aviation Professionals, Inc.:

1.) My permanent residence location and tax home as defined by IRS is:

STREET ADDRESS: _____

CITY, STATE & ZIP CODE: _____

TELEPHONE NUMBER: _____

2.) I perform a portion of my business within the vicinity of my permanent home when residing at my permanent home.

3.) That I incur duplicate expenses because my business requires me to be away from my permanent home.

4.) Members of my family (marital or lineal) reside at my permanent home, or, if I am single, I use my permanent home frequently for lodging.

5.) That the intent of this assignment, located at _____ in _____ is to be temporary in nature.

FURTHERMORE, I ACKNOWLEDGE THAT THE ABOVE STATEMENTS ARE RELIED ON BY AVSOURCE AVIATION PROFESSIONALS, INC. FOR THE PURPOSE OF REMITTING PER DIEM ALLOWANCES AND I HOLD HARMLESS AVSOURCE AVIATION PROFESSIONALS, INC. FROM ANY PENALTIES, BACK TAXES OR INTEREST THAT MY RESULT OF ANY CHANGES IN MY RESIDENCE OF ASSIGNMENT THAT MAKE UNTRUE OR FALSE STATEMENTS MADE ABOVE OR AS A RESULT OF ANY INTERNAL REVENUE SERVICE TAXPAYERS COMPLIANCE EXAMS. I ALSO ACKNOWLEDGE THAT IF ASSIGNMENT EXCEEDS A PERIOD OF TWELVE MONTHS, AND/OR IF THE REPRESENTATIONS CONTAINED HEREIN CHANGE OR CEASE TO EXIST, I MUST NOTIFY THE COMPANY IMMEDIATELY AND PROVIDE A NEW CERTIFICATION.

SIGNATURE: _____ **DATE** _____ **SSN** _____

WITNESS: _____ **DATE** _____

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DIRECT DEPOSIT ENROLLMENT

To enroll in FULL SERVICE DIRECT DEPOSIT, simply fill out this form and give it to your payroll manager. Please attach a voided check for each checking account listed – **not a deposit slip**. If depositing to a savings account, ask your bank to give you a bank letter stating your routing/transit number and account number. This will help ensure you are paid correctly.

Account Information

1. BANK NAME / CITY / STATE: _____

CHECKING SAVINGS I WISH TO DEPOSIT \$ _____ or Entire Net Amount
(Do not enter percentage)

2. BANK NAME / CITY / STATE: _____

CHECKING SAVINGS I WISH TO DEPOSIT \$ _____ or Entire Net Amount
(Do not enter percentage)

3. BANK NAME / CITY / STATE: _____

CHECKING SAVINGS I WISH TO DEPOSIT \$ _____ or Entire Net Amount
(Do not enter percentage)

*****PLEASE NOTE THAT DIRECT DEPOSIT CAN ONLY BE TERMINATED PER WRITTEN REQUEST. SEE ATTACHED DIRECT DEPOSIT TERMINATION FORM FOR INSTRUCTIONS. IT IS YOUR RESPONSIBILITY TO INFORM AAPS OF ANY ACCOUNT CHANGES. IMPORTANT! PLEASE READ AND SIGN BEFORE SUBMITTING. *****

I hereby authorize my employer, Avsource Aviation Professionals, Inc., to deposit any amounts owed me by initiating credit entries to my accounts at the financial institutions indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by AAPS to my accounts. In the event that AAPS deposits funds erroneously into my account, I authorize AAPS to debit my account for the amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until AAPS has received written notice from me of its termination in such time and such manner as to afford AAPS reasonable opportunity to act on it.

Employee PRINTED name: _____ SS# _____

Employee SIGNATURE: _____ Date _____

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**IMPORTANT INFORMATION ABOUT DIRECT DEPOSIT
PLEASE READ**

IF YOU EVER WORKED FOR AVSOURCE AVIATION PROFESSIONALS, INC. IN THE PAST AND WERE SET UP WITH DIRECT DEPOSIT, THAT DIRECT DEPOSIT ACCOUNT INFORMATION IS STILL ACTIVE IN OUR PAYROLL SYSTEM. PLEASE CHECK WITH THE AAPS PAYROLL DEPARTMENT TO VERIFY THAT THE ACCOUNT INFORMATION IN OUR PAYROLL SYSTEM IS CORRECT PRIOR TO YOUR FIRST PAYCHECK DATE. IF THE BANK ACCOUNT INFORMATION WE HAVE ON FILE IS NO LONGER VALID OR YOU NO LONGER WISH TO HAVE DIRECT DEPOSIT, PLEASE COMPLETE THIS FORM AND FAX IT TO THE AAPS PAYROLL DEPARTMENT AT THE NUMBER LISTED BELOW.

_____ I WISH TO CANCEL DIRECT DEPOSIT (If multiple accounts, please indicate which account you would like to cancel.)

BANK NAME: _____

ACCOUNT #(s): _____

Employee PRINTED Name: _____ SS#: _____

Employee SIGNATURE: _____ Date: _____

**PLEASE FAX THIS COMPLETED FORM TO THE
PAYROLL DEPARTMENT AT 859-282-8777**

PLEASE NOTE – DIRECT DEPOSIT CANCELLATION FORMS RECEIVED *AFTER* MONDAY CAN NOT BE PROCESSED FOR THE CURRENT WEEK’S PAYROLL.

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EMPLOYEE BRIEFING – “WHAT TO DO IN CASE OF A WORK-RELATED INJURY”

1. If you've had a work-related injury, contact your Coordinator before going for medical treatment. The only Exception would be a life-threatening injury. If you've tried but cannot get in touch with your Coordinator, contact the AAP's Worker's Compensation Emergency line at 606-425-3416. Remember...not every scratch needs or should be reported. Use good common sense.
2. You will have to fill out the AAP's First Report of Incident prior to going for treatment unless the injury is life threatening.
3. Once you declare a Worker's Compensation incident, we will notify the site HR Director and your Department Manager that you'll be off work until all State, Federal and Site *specific* Contract requirements have been met.
4. REMEMBER: If you feel you have to seek medical treatment, before you can return to duty, you will need a full medical release. This release must be brought to your Coordinator and reviewed and approved by the AAP's Director of Worker's Compensation. **YOU CANNOT RETURN TO WORK WITHOUT PROPER CLEARANCE.**
5. If the treating facility has put you on work restriction, you may not be able to or allowed to return to work. We will try and work with the Director of HR at your site to find work. However, remember, since you are a contractor (a temp and not a direct employee of the site), they may not be able to accommodate your restrictions. We have to clear this with HR, not the Lead or Supervisor; the average time before an unrestricted release is issued has been seven (7) days. There is no compensation until the particular State's waiting period has past, an average of eight (8) days. Should you be out long enough to qualify for pay under Worker's Compensation, remember on average, it will only be 2/3rds of your Taxable Straight Time pay the State uses to figure benefits. In several States, neither per diem nor overtime will be considered towards your benefits.
6. You must contact your Coordinator or the AAP's Worker's Compensation Office after each medical visit and keep us advised of your medical status and when you should be released to full duty. At that time, the Coordinator will set up a time for you to bring in the required documents. This will be sometime Monday thru Friday during normal business hours; but no later than 2:00 PM Eastern Time for an authorization to return to work that day or for the weekend. Not on the weekend, early in the morning or late in the evening. (Check with your Coordinator for the schedule at your site.)
7. **Only the AAP's Corporate Office can authorize your return to work.** Not your Lead, Supervisor or even the Site Coordinator can authorize your return to work. **IF YOU VIOLATE COMPANY POLICY AND WORK WITHOUT FOLLOWING PROPER PROCEDURES, YOU COULD BE IN VIOLATION OF FEDERAL LAW AND SUBJECT TO TERMINATION.**

If you have questions about these regulations, you may call the AAP's Workers Compensation Office at 1-606-425-3416.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Please keep a copy of this Briefing for your records.

**AVSOURCE AVIATION PROFESSIONALS, INC.
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RECEIPT OF THE WORKERS'S COMPENSATION INFORMATION CARD

I, _____, have received the AAP's Workers Compensation Information wallet card. I have been instructed by my Coordinator or Recruiter in the proper procedures to follow in case of a work-related injury. I understand that if I do not follow the proper procedures that my claim may be denied by the State and the Insurance Company. I also reported to my Coordinator, or, in the case of a site without a Coordinator, I must check in with the AAP's Workers Compensation office. Under no circumstances may I work FAA related duties if taking medication which could have a negative effect on my ability to work safely or is prohibitive under the FAR's and/or OSHA regulations. This to, includes medications either prescribed by a doctor or purchased over the counter. I understand that any restrictions placed on me by the physician must be reviewed by the AAP's Workers Compensation office that must then make contact with the appropriate Floor Supervisor, Manager and Human Resources manager to determine if I can be used by this site within the limits of said restrictions. I understand that working with restrictions without obtaining the consent of the Workers Compensation office and the Site HR Department may result in my termination from that site.

I acknowledge that the image below is a reasonable facsimile of the card I received.
(Please make a copy of this card and carry with you at all times.)

Date: _____

Print Name: _____

Signature: _____

AVSOURCE AVIATION PROFESSIONALS, INC
(AAPS)
IN CASE OF WORK RELATED INJURY
INFORM YOUR EMPLOYER IMMEDIATELY
CONTACT YOUR AAPS COORDINATOR FIRST
OR, IF THE COORDINATOR DOESN'T RESPOND, CALL
1-606-425-3416
Remember...if you work SAFE and don't get hurt you
won't need this card

STEPS TO FOLLOW IF INJURED ON THE JOB
NOTIFY YOUR COORDINATOR, IF NO RESPONSE
CALL AAPS WORKERS COMP OFFICE.
To be covered under Worker's Compensation an
injury must be reported to AAPS immediately.
**FAILURE TO FOLLOW CORRECT PROCEDURES COULD
RESULT IN A DENIAL OF YOUR CLAIM**
Please direct all questions or concerns to you Coordinator or
the **AAPS Worker's Compensation Administration Office**
7430 US Hwy 42-Suite 208, Florence, KY 41042
Phone 606-425-3416 FAX 859-282-8777

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BACKGROUND REQUIREMENTS

If this form is not filled out completely and in a manner that can be read clearly, it can NOT be processed and could affect your ability to obtain employment with AVSOURCE AVIATION PROFESSIONALS, INC.

Social Security Number ___ ___ - ___ ___ - ___ ___ ___ **Date of Birth** _____

Your full name, as it appears on your Social Security Card. (No Nicknames)

First	Middle	Last
--------------	---------------	-------------

Maiden or Other Name Formerly Used _____ **Date Last Used (MM – YY)** _____

Sex: Male ___ Female ___ (Some jurisdictions require this info to process a requested search)

Race: White ___ African American ___ Hispanic ___ Asian (Pacific Islander) ___

American Indian ___ Alaskan Native ___ Other (please specify) ___

LICENSE INFORMATION

For Valid or Non-Valid Driver's License, complete the following:

Date Issued: _____ **Expiration Date:** _____ **Issuing State:** _____

DRIVER'S LICENSE NUMBER: _____

A & P LICENSE NUMBER: _____

FCC LICENSE NUMBER: _____

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PLEASE CHECK THE APPROPRIATE RESPONSE TO THE FOLLOWING QUESTIONS:

1. Within the *past seven (7) years* have you been convicted of a crime that has not been expunged from your record? (Include offenses for which you served probation, paid a fine and / or served a jail sentence.)

_____ NO _____ YES If yes, fill in below:

Date: _____ City: _____ State: _____

DETAILS:

2. Are you currently on probation or parole for a criminal offense or have you received an alternative disposition sentence for a criminal act? _____ NO _____ YES If yes, fill in below:

Date: _____ City: _____ State: _____

DETAILS:

NOTE: A conviction does not automatically mean you cannot be employed. Factors such as your age at the time of conviction, how long ago it occurred, the reason for the conviction and the rehabilitation you received will all be considered.

I certify that the information contained herein is true and understand that any falsification will result in the rejection of my application or termination of my employment. I also understand that the requested information is for the sole purpose of conducting a background investigation which may include a check of my identity (including my Social Security number for validation), work and credit history, driving records and any criminal history which may be in the files of any state or local criminal agency. Information regarding age, sex or race will not be used as part of any employment decision. A telephone facsimile of this authorization shall be valid as the original.

I hereby authorize this company, its corporate affiliates, its employees, its authorized agents and representatives (including ADP) to verify all information contained in this form or in my application and to inquire into my character, general reputation, personal characteristics and mode of living. I further agree that should I accept an offer of employment, the company may need to update this information or conduct subsequent investigations from time to time during my employment and I expressly authorize such acts. I hereby release this company, its corporate affiliates, its employees, its authorized agents and representatives and all others involved in this background investigation from any liability in connection with any information they give or gather and any decisions made concerning my employment based on such information. I understand that any offer of employment I may receive is contingent upon the successful completion of the background investigation. I further understand that I have the right, under Section 606(B) of the Fair Credit Reporting Act, to make a written request to this company within a reasonable period of time for a complete and accurate disclosure of the nature and scope of the investigation requested.

APPLICANT SIGNATURE: _____

PRINT FULL NAME: _____ DATE: _____

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O.J.T. DOCUMENTATION FORM

O.J.T. TASK DOCUMENTED	DATE	TYPE OF A/C	A/C NUMBER "N"	EMPLOYEE	TRAINER, LEAD SUPERVISOR	COMPLETION TIME H/M	MAINT MANUAL REFERENCE
<i>Ex: Remove & Replace main tire assembly</i>	<i>4/13/2009</i>	<i>B757</i>	<i>N8100A</i>	<i>Initial Here</i>	<i>Signature: qualified per FAR 65.81</i>	<i>1.5</i>	<i>32-00-00</i>

EMPLOYEE NAME: _____ SKILL: _____ SSN: _____

EMPLOYEE SIGNATURE: _____ LOCATION: _____

<u>ATA Specification 100 Maintenance Chapter Number Reference</u>			
5 Time Limits & Check	23 Communications	34 Navigation	57 Wings
6 Dimensions & Charts	24 Electrical Power	35 Oxygen	70 Standard Practices - Engines
7 Lifting & Shoring	25 Equipment / Furnishings	36 Pneumatics	71 Power Plant
8 Leveling & Weighing	26 Fire Protection	38 Water & Waste	72 Engine
9 Towing & Taxing	27 Flight Controls	49 Airborne Auxiliary Power	73 Engine Fuel & Control
10 Parking & Mooring	28 Fuel	51 Structures - General	74 Ignition
11 Required Placards	29 Hydraulic Power	52 Doors	75 Air
12 Servicing	30 Ice & Rain Protection	53 Fuselage	
20 Standard Practices -Airframe	31 Instruments	54 Nacells / Pylons	
21 Air Conditioning	32 Landing Gear	55 Stabilizers	
22 Auto Flight	33 Lights	56 Windows	

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