



United States Drilling Inc.

GENERAL ACKNOWLEDGMENTS

Pay Periods

My supervisor has explained to me that the pay period ends on Thursday night of every other week. It is my responsibility to make sure that my hours worked are recorded in Pason with the correct position. I understand that I will receive my pay through direct deposit on the Second Friday following the end of the pay period. If I elect to have my payroll check mailed, payday is on the second Monday following the end of the pay period. I further understand that **there are no pay advances.**

Initials _____

Personal Information

I understand that all information contained in this "employee packet" is personal and confidential. I also understand that ENSIGN will discuss any personal information and/or problems **only** with the **employee.**

Initials _____

Safety

I have read the policies and procedures set forth in the ENSIGN Accident Prevention and Safety Program. I understand and agree to comply with these policies and procedures. I have also read the rules and guidelines in the Employee Safety Manual. I agree to follow these rules and guidelines and have signed the acknowledgment certificate located at the back of the manual.

Initials _____

Hazard Communication

I have been instructed on the proper use and handling of chemicals in the workplace. My supervisor has provided me with training on the ENSIGN "Hazard Communication Program", the location of the material safety data sheets (MSDSs), how to read and interpret the information on labels and MSDSs, and the proper use of personal protective equipment.

Initials _____

Designated Medical Providers for Work Related Injuries/Illness and Authorization to Release Information

I understand that I may be required to obtain medical treatment from a ENSIGN authorized medical provider if I am injured on the job. (In the event of life- or limb-threatening emergencies, injured employees are taken to the nearest medical facility.) I also understand that if an unauthorized provider treats me, I may be responsible for payment of such treatment. I authorize all medical providers who treat me for any injury/illness occurring while at work for ENSIGN to release all information related to the treatment of that injury/illness to ENSIGN. The information that may be released includes: description of injury, the medical services I have received, and the dates of those services. In addition, workers' compensation benefits may be reduced by 50 percent for using drugs or alcohol, the willful failure to use safety devices, or willfully violating established safety rules.

Initials _____

I have read and understand all of the information furnished above as evidenced by my initials following each section.

Name _____ Date _____
(Please print)

Signature _____