

# EMPLOYMENT APPLICATION

<p><b>Applicant Instructions</b>                  If you need help filling out this application form for any phase of the employment process, please notify the person that gave you this form and every effort will be made to accommodate your needs in a reasonable amount of time.</p> <ol style="list-style-type: none"> <li>1. Please read "APPLICANT NOTE" below.</li> <li>2. Complete both sides of this paper.</li> <li>3. If more space is needed to complete any question, use comments section on the back of this paper.</li> <li>4. Print Clearly: incomplete or illegible application will not be processed.</li> <li>5. Some packets may include an affirmative action questionnaire. This information is being gathered for affirmative action under Section 503 of the Rehabilitation Act of 1973. The information requested is voluntary and will be kept confidential. As applicant will not be subject to any adverse treatment for refusing to complete the questionnaire.</li> <li>6. DO NOT FILL OUT ANY OTHER ATTACHED FORMS OR PAGES UNTIL INSTRUTCTED.</li> </ol>	<p><b>TODAYS DATE:</b> _____</p> <p><b>NAME:</b> _____</p> <p><b>SOCIAL SECURITY NUMBER</b> _____</p> <p><b>HOME PHONE:</b> _____ <b>WORK:</b> _____</p> <p><b>CURRENT ADDRESS:</b> _____  <small style="display: block; text-align: center;">STREET CITY/STATE ZIP</small></p> <p><b>PRIOR ADDRESS:</b> _____  <small style="display: block; text-align: center;">STREET CITY/STATE ZIP</small></p>
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**APPLICANT NOTE** – This application form is intended to use in evaluating your qualifications for employment. This is not an employment contract. Please answer all appropriate questions completely and accurately. False or misleading statements during the interview and on this grounds for terminating the application process or if discovered after employment, terminating employment. All qualified applicants receive consideration without discrimination because of sex, marital status, race, age, creed, national origin or the presence of disabilities. A felony conviction will not necessarily bar an applicant from employment. Affirmative action hiring may be requested by qualified applicants. Additional testing of job-related skills and for the presence of drugs in your body may be required prior to employment. After an offer of employment and you report to work, you are required to submit to a medical review. Depending on company policy and the needs of the job, you will be requested to complete a medical history form and may be required to be examined by a medical professional designated by the company.

**AVAILABILITY** For which position are you applying? \_\_\_\_\_  
 What date can you start? \_\_\_\_\_ What category would you prefer?  Full-Time  
 – Part-time  – Temporary  – Labor  
 For which schedules are you available?  – Weekdays  – Weekends  – Evenings  – Nights  
 – Overtime  – Shift  – Other

**EDUCATION** - Please circle grades completed. 7 8 9 10 11 12 13 14 15 16 16+

Name	City/State	Graduate?	Degree?
High school			
College			
Other			

**SECURITY** -- List states and counties of residence for the past seven (7) years.

Have you used any names or Social Security Numbers other than those on this page? If so, please list on back.  – YES  – NO  
 Have you been convicted of, or served time for a felony in the past seven years? If so, please describe below.  – YES  – NO

Incident	City/State	Charge

**COMMENTS**

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**CERTIFICATION AND RELEASE**

***I CERTIFY THAT I HAVE READ AND UNDERSTAND THE APPLICANT NOTE ON PAGE ONE (1) OF THIS FORM AND THAT THE ANSWERS GIVEN BY ME TO THE FOREGOING QUESTIONS AND THE STATEMENTS MADE BY ME ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT ANY FALSE INFORMATION, OMISSIONS OR MISREPRESENTATIONS OF FACTS CALLED FOR IN THIS APPLICATION MAY RESULT IN REJECTION OF MY APPLICATION AND DISCHARGED AT ANY TIME DURING MY EMPLOYMENT. I AUTHORIZE THE COMPANY AND/OR OTS AGENTS, INCLUDING CONSUMER REPORTING BUREAUS; TO VERIFY ANY OF MY BACKGROUND AND HEREBY RELEASE ANY SAID PERSONS, SCHOOLS, COMPANIES AND LAW ENFORCEMENT AUTHORITIES FROM ANY LIABILITIES FOR ANY DAMAGE WHATSOEVER FOR ISSUING THIS INFORMATION. I ALSO UNDERSTAND THAT THE USE OF ILLEGAL DRUGS IS PROHIBITED DURING EMPLOYMENT. OF COMPANY POLICY REQUIRES, I AM WILLING TO SUBMIT TO DRUG TESTING TO DETECT THE USE OF ILLEGAL DRUGS PRIOR TO AND DURING EMPLOYMENT.***

<b><i>SIGNATURE</i></b>	<b><i>DATE</i></b>
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### III

Are you taking any long term (more than 30 days) prescribed medication?  - YES  - NO

If yes, please describe:

A) type of medication \_\_\_\_\_

B) purpose \_\_\_\_\_

C) side effects \_\_\_\_\_

### IV

Do you have or have you been diagnosed as having any illness or injury for which you are not seeking treatment?  - YES  - NO

If yes, please describe: \_\_\_\_\_

### COMMENTS:

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### AFFIRMATION AND AUTHORIZATION

*I hereby affirm that the information on this form is true and correct and that there are no omissions. I authorize any physician, medical facility, law enforcement agency, administrator, state agency, institution, information service bureau, insurance company or employer contacted by this company or an agent of this company to furnish or verify workers compensation information and medical records.*

*I further acknowledge that a telephone facsimile (FAX) or photographic copy shall be as valid as the original.*

Today's Date	Signature
Today's Date	Authorized Signature of Company Representative

*\* Upon successful completion of this review you will be given a start date.*

<b><i>FOR EMPLOYER USE ONLY</i></b>
VERIFICATION (Personnel Administrator)
MEDICAL REVIEW (Medical Professional)

### PERSONAL AND CONFIDENTIAL

Store in secure "Medical Only" files