

ROCKY MOUNTAIN FLAGGING, INC.

• EMPLOYMENT APPLICATION •

APPLICANT INSTRUCTIONS:

If you need help filling out this application form or 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.

1. Please read *APPLICANT NOTE* below.
2. Complete both sides of this page.
3. If more space is needed to complete any question, use comments section at the bottom of this page.
4. Print clearly. Incomplete or illegible applications will not be processed.
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. An applicant will not be subject to any adverse treatment for refusing to complete the questionnaire.
6. DO NOT FILL OUT ANY OTHER ATTACHED FORMS OR PAGES UNTIL INSTRUCTED.

TODAY'S DATE: _____

NAME: _____
LAST FIRST M.I.

SOCIAL SECURITY NUMBER: _____

HOME PHONE: _____

CURRENT ADDRESS: _____
STREET

_____ CITY STATE ZIP

PRIOR ADDRESS: _____
STREET

_____ CITY STATE ZIP

APPLICANT NOTE: This application form is intended for 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 form are grounds for termination of the application process, or if discovered after employment, terminating employment. All Qualified Applicants will receive consideration without regard to disability, race, creed, color, sex, sexual orientation, religion, age, national origin, or ancestry. A felony conviction will not necessarily bar an applicant from employment. **After an offer of employment, and prior to reporting to work, you are required to submit to drug testing and a medical review. Depending on company policy and the needs of the job, you may also 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 pool
 For which schedules are you available? Weekdays Weekends Evenings Nights Overtime Shift Other _____

JOB RELATED SKILLS: NOTE: Do not fill out any part of this section you believe to be non-job related.

- Yes No If the job requires, do you have the appropriate valid driver's license?
 Name on license _____
 DL# _____ Type _____ State of Issue _____
- Yes No Have you had any moving violations? Please describe. _____
 Please list any other skills, licenses, or certificates that may be job-related or that you feel would be of value to this job or company: _____
- Yes No Have you been given a job description or had the requirements of the job explained to you?
 Yes No Do you understand these requirements?
 Yes No Can you perform the requirements of this job with or without reasonable accommodation?
 List languages in which you are fluent. _____

SECURITY: List states and counties of residence for the past seven years: _____

- Yes No Have you used any names or Social Security Numbers other than given above? If so, please list in COMMENTS, below.
 Yes No Have you been convicted of, or served time for, a felony in the past seven years? If so, please describe in the boxes below.
 (In accordance with company policy this information will be reviewed for job relatedness and time since last conviction.)

INCIDENT	CITY/STATE	CHARGE
1.		
2.		

COMMENTS: _____

ROCKY MOUNTAIN FLAGGING, INC.

PREVIOUS EMPLOYERS:

PLEASE NOTE. Your application will **not be** considered unless every question in this section is answered. Since we will make every effort to contact previous employers, the *correct telephone numbers of past employers are critical*. Go to your previous employer's website to get the correct phone numbers, if necessary.

MOST RECENT EMPLOYER <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently working for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, may we contact?		
		Phone () - FAX () -
COMPANY NAME _____	CITY _____	STATE _____
FROM _____ TO _____	DATES EMPLOYED _____	
DUTIES _____		SUPERVISOR NAME _____
SALARY _____ PER _____		REASON FOR LEAVING _____
SECOND MOST RECENT EMPLOYER		
		Phone () - FAX () -
COMPANY NAME _____	CITY _____	STATE _____
FROM _____ TO _____	DATES EMPLOYED _____	
DUTIES _____		SUPERVISOR NAME _____
SALARY _____ PER _____		REASON FOR LEAVING _____
THIRD MOST RECENT EMPLOYER		
		Phone () - FAX () -
COMPANY NAME _____	CITY _____	STATE _____
FROM _____ TO _____	DATES EMPLOYED _____	
DUTIES _____		SUPERVISOR NAME _____
SALARY _____ PER _____		REASON FOR LEAVING _____

REFERENCES: Include only individuals familiar with your work ability Do not include relatives.

NAME	ADDRESS/PHONE	YEARS KNOWN/RELATIONSHIP
1.		
2.		

EDUCATION: Please circle highest grade completed 7 8 9 10 11 12 13 14 15 16 16+

If your school records are under a different name than above, please enter that name: _____

NAME	CITY/STATE	GRADUATE?	DEGREE?
HIGH SCHOOL			
COLLEGE			
OTHER			

CERTIFICATION AND RELEASE: I certify that I have read and understand the *APPLICANT NOTE* on page one 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 or discharge at any time during my employment. I authorize the company and/or its agents, including consumer reporting bureaus, to verify any of this information. I authorize all former employers, persons, schools, companies, and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I also understand that the use of illegal drugs is prohibited during employment. If company policy requires, I am willing to submit to drug testing to detect the use of illegal drugs prior to and during employment.

SIGNATURE	DATE
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ROCKY MOUNTAIN FLAGGING, INC.

• CONDITIONAL JOB OFFER •

APPLICANT NAME _____

POSITION _____

DATE OF JOB OFFER _____

Based on qualifications presented on your application form and/or in your job interview, you are hereby offered a job with our organization conditional upon submitting to our standard medical review and the verification of your answers to the following questions. Your job offer will not be rescinded unless you do not submit to and pass any required drug screening, a medical review reveals that you cannot perform the essential functions of the job (with reasonable accommodations, if requested), you present a hazard to yourself or others, or you are found to have made or you make false or misleading statements in your job interview or the application process. This offer is valid only if an authorized company representative has signed below.

Today's Date _____

Signature of Authorized Company Representative _____

Applicant: These sections are to be completed *only* after you have been given an offer of employment.

MEDICAL REVIEW--TO BE COMPLETED ONLY AFTER CONDITIONAL JOB OFFER HAS BEEN MADE

This form must be accurate and complete for us to process. This information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with applicable privacy laws.

EMERGENCY INSTRUCTIONS:

In case of emergency, contact:

NAME _____

PHONE NUMBER _____

CITY/STATE _____

Are there any other emergency instructions, circumstances, medical needs, allergic responses, or procedures the company should know?*

(CONTINUE IN COMMENTS SECTION ON BACK IF NECESSARY)

*If you have an allergy that requires that an epinephrine injection (such as by an EpiPen or other autoinjector) be administered, be advised that you are responsible for carrying your own EpiPen or other device on your person at all times.

HEALTH AND SAFETY:

I. Yes No

If yes, please describe:

- a) date of injury
- b) employer
- c) body part affected
- d) cause
- e) amount of lost time
- f) any permanent disability (%)?
- g) was worker's comp claim filed?

Have you had any injury or injuries on the job?

1	2	3

Please list any others in comment section on the back

II. Yes No

If yes, please describe:

- a) date of injury/illness
- b) body part affected
- c) cause
- d) days in hospital
- e) days lost work time
- f) have you recovered?

Do you have, or have you had, other injuries or illnesses not on the job (home, auto, sports, hunting, etc.) that have resulted in hospitalization, surgery, or lost work time?

1	2	3

Please list any others in comment section on the back

••• PERSONAL AND CONFIDENTIAL •••

ROCKY MOUNTAIN FLAGGING, INC.

III. Yes No

Are you taking any long term (more than 30 days) prescribed medication that could interfere with your ability to perform the essential functions of this job?

If yes, please describe:

- a) type of medication
- b) purpose
- c) side effects

1	2	3

IV. Yes No

Do you have or have you been diagnosed as having any illness or injury that could affect your ability to perform the essential functions of this job for which you are not seeking treatment?

If yes, please describe:

COMMENTS: _____

AFFIRMATION AND AUTHORIZATION:

I hereby affirm that the information on this form is true and correct and that there are no omissions. I authorized 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 worker's 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

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

Today's Date

Authorized Signature of Company Representative

• FOR EMPLOYER USE ONLY •

VERIFICATION (Personnel Administrator) _____

MEDICAL REVIEW (Medical Professional) _____

••• PERSONAL AND CONFIDENTIAL •••