



Employment Application

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: () _____ E-mail Address: _____

Date Available: _____ Social Security No.: _____ Desired Salary: \$ _____

Position Applied for: _____

Are you employed now?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If employed and under 18, can you furnish a work permit?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you a citizen of the United States?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, are you authorized to work in the U.S.?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever worked for this company?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, when?	_____	
Do you have a valid driver's license in this state?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	License #	_____	
Have you ever been convicted of a felony?	YES <input type="checkbox"/>	NO <input type="checkbox"/>			

If yes, explain: _____

Can you perform the essential functions of the job(s) for which you are applying? YES NO

Are you available to work: Full-Time Part-Time Over-Time

This company is an equal employment opportunity employer. All applicants will be considered without regard to age, color, national origin, religion, disability, sex or other protected status in accordance with applicable federal and state equal employment opportunity laws. This company will strive to accommodate any physical or mental limitations of employees or applicants in order to accomplish the essential functions of a job.

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

Special Skills, Qualifications and Considerations:

Summarize special skills and qualifications, volunteer activities, military experience, employment or other activities related to the job you are seeking:

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: () _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: () _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: () _____

Address: _____

Previous Employment

Company: _____ Phone: () _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Company: _____ Phone: () _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Company: _____ Phone: () _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING THIS APPLICATION. ONLY THOSE APPLICATIONS THAT ARE SIGNED AND DATED ARE CONSIDERED VALID. IF YOU HAVE ANY QUESTIONS REGARDING THIS STATEMENT, PLEASE ASK THEM BEFORE SIGNING.

I certify that all answers and statements I have made on this application (and resume or other supplementary materials) are true and complete without omissions. I understand that any false information will result in a refusal to hire or immediate discharge if I am employed. I authorize any of the persons or organizations named in this application to give you complete information and records regarding my employment, education, character and qualifications. YES NO

If hired I will be responsible for familiarizing myself with all rules and regulations of Bob Hull, Inc. as they presently exist or are later modified. *If hired, I understand my employment can be terminated, at the discretion of the company or at my option, without notice, at any time, except as specifically set forth in writing in a current individual employment agreement, which I have entered into with the company* . YES NO

I also understand that no representative of Bob Hull, Inc. has any authority to enter into any employment agreement for any specified period of time, or to assure me of any future position, benefits, or terms and conditions of employment, except as specifically stated in a current written agreement signed by the President. YES NO

I understand this application is not an offer of employment and no promises or representations of employment have been made to me at this time. YES NO

By signing below, I authorize Bob Hull, Inc. to investigate all statements contained in this employment application as they may deem necessary in arriving at an employment decision. I further authorize Bob Hull, Inc. to order one or more consumer reports containing financial, driving record, and/or other information about me from a consumer reporting agency. I understand that the consumer report(s) will be requested and used for the purpose of evaluating me for employment, promotions, transfers, and/or retention as an employee.

I have read, understand, and agree with the above.

Signature of Applicant

Date

This application is valid for only ninety (90) days from the date I signed. If I want to be considered for job openings more than (90) days from date signed, I will submit a new application.

Applicant's Name _____

Social Security # _____

- | | Check One | Explain |
|---------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------|
| 1. TUBERCULOSIS | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 2. CANCER | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 3. ASTHMA | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 4. EMPHASEMA | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 5. DIABETES | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 6. MENTAL DISORDER | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 7. NERVOUS DISORDER | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 8. POLIO | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 9. HERNIA | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 10. MULTIPLE SCLEROSIS | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 11. EPILEPSY | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 12. ULCERS | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 13. ARTHRITIS | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 14. LUNG CONDITION/DISEASE | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 15. HEART CONDITION/DISEASE | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 16. KNEE PROBLEMS | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 17. FINGERS OR TOES MISSING | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 18. LOSS OF HEARING | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 19. LEAD POISONING | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 20. LOSS OF SIGHT | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 21. KIDNEY TROUBLE | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 22. SKIN DISEASE | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 23. ALLERGIES | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 24. STROKE | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 25. SHOULDER INJURY | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 26. BAD JOINTS | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 27. BACK SURGERY | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 28. BACK INJURY/TROUBLE | <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| 29. A. HAVE YOU EVER RECEIVED SERIOUS INJURIES IN AN ACCIDENT?
B. EXPLAIN | | |
| 30. HAVE YOU EVER RECEIVED WORKERS COMPENSATION MEDICAL AND/OR SALARY COMPENSATION? EXPLAIN | | |
| 31. MILITARY SERVICE DISSABILITY? | | |
| 32. LIST ANY OTHER ILLNESS OR PHYSICAL CONDITION NOT MENTIONED ABOVE. | | |

I have read the above, know and understand my answers made to the question and I declare that all of my answers are true. Complete and correct to the best of my knowledge. If requested I will furnish a doctor's statement regarding any condition which I have listed on this questionnaire.

Applicant Signature

Date