

EVERETT WHITEHEAD & SON CONSTRUCTION, INC.

Drug Free Workplace • Equal Opportunity Employer

Application for Employment

Date: _____

PERSONAL DATA

Name: _____ SS#: _____

Present Address _____

Previous Address: _____

Telephone Number: _____

Are you over the age of 18? Yes No *If no, employment is subject to verification that you are of minimum legal age.*

Are you authorized to work in the United States? Yes No

Do you have a valid Florida Driver's License? Yes No License No.: _____

Do you have your own transportation? Yes No

EMPLOYMENT OBJECTIVES

Position Desired: _____ Hours Desired: _____

Salary Requirements: _____

GENERAL INFORMATION

How were you referred to us? _____

Are you presently employed? Yes No If yes, what notice will be required? _____

What date will you be available for employment? _____

Can you perform all of the job related functions of the position desired? Yes No If no, please explain:

Relatives/Friends employed here (state name and relationship): _____

EDUCATIONAL ATTAINMENT

Year graduated from school: Grammar _____ High _____ Studying now?

Vocational _____ Commercial _____ College _____ Yes No

LICENSES

List any Professional Licenses and/or Certifications you hold.

Type	State	Exp. Date	License #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REFERENCES

List three personal references other than former employees and relatives.

Name	City, State	Occupation	Telephone	Years Known
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PAST/PRESENT EMPLOYMENT

Employer #1: _____ From: _____ To: _____
Address: _____ Phone: _____
Job: _____ Salary: _____ Reason For Leaving: _____
Employer #2: _____ From: _____ To: _____
Address: _____ Phone: _____
Job: _____ Salary: _____ Reason For Leaving: _____
Employer #3: _____ From: _____ To: _____
Address: _____ Phone: _____
Job: _____ Salary: _____ Reason For Leaving: _____
Employer #4: _____ From: _____ To: _____
Address: _____ Phone: _____
Job: _____ Salary: _____ Reason For Leaving: _____

HEALTH

Do you have, or have you ever had, any of the following physical conditions, ailments or diseases? *Answer Yes or No.*

Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Silicosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism or Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Trouble or Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Trouble or Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arteriosclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nervousness or		Wear Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nervous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead Poisoning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rupture or Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes, give details as to time, duration, treatment and names of doctors: _____

Have you ever had a military or job-connected disease or injury? Yes No
If Yes, did you receive Compensation? Yes No Medical Benefits? Yes No How Long? _____
Do you have any physical disability or impairment? Yes No
Have you ever been rated with a permanent disability? Yes No
Have you ever injured or sprained your back? Yes No
If Yes, did it happen on the job? Yes No Off the job? Yes No
Did you receive treatment from a doctor? Yes No
Are you fully recovered from previous injuries or sickness you have had? Yes No
Have you ever received any benefits or a disability under the Workers' Compensation Act of Florida? Yes No Any other state? Yes No

I certify the above answers to be true and correct, and understand that any false or misleading statements to these questions may be reason for denial of benefits under the Florida Workers' Compensation Act. I also acknowledge and understand the provisions under the Florida Workers' Compensation Act which state that "Any person who willfully makes any false or misleading statement, or representation for the purpose of obtaining or denying any benefit or payment under this chapter: (A) Who presents, or causes to be presented any provision of this chapter, knowing that such statement contains any false or misleading information concerning any fact or thing material to such claim, or (B) Who prepares or makes any written or oral statement that is intended to be presented to any employer, insurance company, or self-insured program in connection with, or in support of any claim for payment or other benefit pursuant to any provision of this chapter, knowing that such statement contains any false or misleading information concerning any fact or thing material to such claim, shall be guilty of a felony of the third degree, punished as provided in "S.775.082, S.775.083, or S.775.084."

Your Signature: _____ Date: _____
Witness Signature: _____ Manager's Signature: _____

APPLICANT'S STATEMENT

I certify that the information contained in this application is correct to the best of my knowledge and understand that falsification of this information is grounds for dismissal. I understand that this application will be given every consideration, but its receipt does not imply that the applicant will be employed.

I give my permission to the Company to contact any former employers or references listed to verify the information I have given and to release all records of my employment, including assessments of my job performance and ability.

I understand that any offer of employment by the Company will be conditioned upon a post offer medical examination/drug test performed prior to employment. I hereby give my consent to such examination(s).

I agree to conform to the rules and regulations of the Company. I understand that my employment can be terminated with or without cause and with or without notice at any time, at the option of either the Company or myself.

Signature: _____ Date: _____