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	❑ Yes ❑ No	Silicosis	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Rheumatism or Gout	❑ Yes ❑ No	Hearing Defects	❑ Yes ❑ No
Back Trouble or Injury	❑ Yes ❑ No	Neck Trouble or Injury	❑ Yes ❑ No	Allergy	❑ Yes ❑ No
Hemophilia	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Eye Trouble	❑ Yes ❑ No
Heart Trouble	❑ Yes ❑ No	Varicose Veins	❑ Yes ❑ No	Arteriosclerosis	❑ Yes ❑ No
Nervousness or		Wear Glasses	❑ Yes ❑ No	Mental Trouble	❑ Yes ❑ No
Nervous Disorder	❑ Yes ❑ No	Lead Poisoning	❑ Yes ❑ No	Rupture or Gout	❑ Yes ❑ 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: _____