OFFICE APPLICATION

Date of Application: _____

Name: _____
Last First Middle Maiden

Address: _____
Street City State Zip How Long

Phone: (_____)_____ Social Security #: _____ - _____ - _____

Date of Birth: _____ Are you a U.S. citizen or authorized to work in the U.S.? ❒ Yes ❒ No

Are you applying for a full-time or part-time position? _____

Are you restricted to shifts, hours, or days you can work? ❒ Yes ❒ No

If "Yes," what are those restrictions? _____
_____

Have you ever been convicted of a felony? ❒ Yes ❒ No

If "Yes," explain: _____
_____

Are you presently employed? ❒ Yes ❒ No May we contact your present employer? ❒ Yes ❒ No

When would you be available to start work? _____

Please list your experience with computers:

Do you have telephone experience? Y N

Do you have dispatching experience? Y N

How familiar are you with Port Townsend, Sequim, Port Angeles areas?

Are you comfortable working under stressful conditions? Y N

Explain your reason for applying for this position:
_____

_____

EMPLOYMENT HISTORY .

Employer: _____

Address: _____ Phone #: _____

Start Date: _____ Wage: _____ Position: _____

End Date: _____ Wage: _____ Position: _____

Supervisor's Name: _____

Responsibilities: _____

Reason for Leaving: _____

Employer: _____

Address: _____ Phone #: _____

Start Date: _____ Wage: _____ Position: _____

End Date: _____ Wage: _____ Position: _____

Supervisor's Name: _____

Responsibilities: _____

Reason for Leaving: _____

Employer: _____

Address: _____ Phone #: _____

Start Date: _____ Wage: _____ Position: _____

End Date: _____ Wage: _____ Position: _____

Supervisor's Name: _____

Responsibilities: _____

Reason for Leaving: _____

I certify the information provided in this employment application to be true and complete to the best of my knowledge. I understand false statements on this application could be cause for dismissal should I become employed.

I authorize previous employers and persons listed in this application to provide any information regarding employment, education, or references. I agree this company, previous employers, or individuals will not be held liable in any respect if I am not employed or employment is terminated because of false statements, omissions, or answers made by myself on this application.

I understand that employment with this company is "at will" and that the company or I can terminate the employment relationship at any time, with or without prior notice and for any reason not prohibited by law.

Signature _____ Date _____

HEALTH QUESTIONNAIRE

Physician's Name: _____ Date of Last Physical Exam: _____

A. Do you have a loss or impairment of the use of a foot, a leg, a hand, fingers, thumb, or an arm, or any other structural defect or limitation which is likely to interfere with ability to operate a vehicle safely? _____

B. Do you have a medical history or clinical diagnosis of the following?
   1) Diabetes requiring use of insulin or any other hypoglycemic medication? _____
   2) Heart ailments such as, Myocardial infarction, angina pectoris or coronary insufficiency? _____
   3) Other forms of cardiovascular disease, including hypertension, with syncope, dyspnea, loss of consciousness, collapse, or congestive failure? _____
   4) Respiratory dysfunction likely to interfere with ability to operate a vehicle safely? _____
   5) Rheumatic, arthritic, orthopedic, muscular, or neuromuscular disease which could interfere with ability to control a vehicle? _____
   6) Epilepsy or other condition which may cause momentary lapses in consciousness likely to cause loss of ability to control a vehicle? _____

C. Do you have any mental, nervous, organic, or functional disease likely to interfere with ability to operate a vehicle safely? _____

D. Do you have a hearing loss no greater than 25 decibels at frequencies of 500, 1,000 and 2,000 in the better ear, without a hearing aid? _____

E. Do you now or have you ever had a problem with alcohol or drug abuse? _____

F. Do you have 20/40 combined vision, corrected and/or uncorrected both eyes? _____
   Do you have 160 degrees field of vision bilaterally? _____
   Do you have sufficient color perception so as not to hinder recognition of common traffic control signs and signals? _____

G. Do you have any type of tuberculosis in a transmittable stage? _____

H. Do you have any physical limitations that would prevent you from:
   1) Lifting 60 lbs? _____
   2) Sitting for long periods of time? _____
   3) Twisting or bending? _____

I. Are you presently using any medication? Yes _____ No _____
   If "Yes," please list: _____
   _____
   _____

The above statements are correct and true to the best of my knowledge.

_____
Employee Signature Date