LABORER APPLICATION

TO ALL LABORER APPLICANTS:

Please Note: A3M is a twenty-four (24) hour, seven (7) day a week company. All applicants must be able to work seven (7) days a week.

You must fill out this application completely to be considered as a potential employee. All information requested is important to us, if you leave anything blank you may not be considered for employment.

1. Do you have a home phone number? ______ YES ______ NO
   (Neighbor's phone number is not accepted)

2. Do you have transportation to and from A3M's Yard and/or job site for work? ______ YES ______ NO

3. Please list someone to notify in case of an emergency: ______________________________
   Telephone #: ______________________________

REQUIREMENTS:

1. Must be at least 18 years of age.
2. You must pass a drug test.
   *Note: "Cold and Hot Samples" terminate eligibility for employment.

JOB DESCRIPTION:

<u>Control Waste Handler (CWH)</u> – an employee of A3M Vacuum Services whose responsibilities include and all physical work needed to complete the job. This includes working the hoses, shoveling, sweeping, etc.

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APPLICANTS

If you have any of the following qualifications please be sure to give a copy of your card(s) to the receptionist so that he/she can attach them to your application.

Check any of the following that you are qualified in:

GBIRMA ______ Expires: ____________________

GNOIC ______ Expires: ____________________

TWIC ______ Expires: ____________________

Dupont ______ Expires: ____________________

Others:

__________________ Expires: ____________________

__________________ Expires: ____________________

__________________ Expires: ____________________

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APPLICANT INFORMATION

Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Date Available	Social Security No.	Desired Salary	
Position Applied for			

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If so, when?

Have you ever been convicted of a felony? YES ☐ NO ☐ If yes, explain

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

PERSONAL

Provide dates you attended school:

Elementary	From:	To:	# of Dependants, including yourself
High School	From:	To:	Are you a Vietnam Veteran? YES NO
College	From:	To:	Sex: Male Female
Marital Status	Single Engaged Married Separated Divorced Widows		Date of Marriage
Previous Address			Are you a U.S. Citizen YES NO
Address			How long at present address? ________________Years
Have you ever been bonded?	YES NO		If YES, with what employers?
Have you been convicted of a crime in the past 10 years?	YES NO		If YES, describe:

State names of relatives and friends working for us:

Have you received Worker's Compensation or Disability Income payments? YES NO

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Do you have physical defects which preclude you from performing certain jobs? YES NO If YES, describe limitations:

Have you had any major illness in the past 5 years? YES NO If YES, please describe:

Do you have any physical condition which might limit your ability to perform the job for which you are applying? YES NO
If YES, describe this condition and how you can perform the job in spite of it.

Are you willing to take a Drug Test? YES NO

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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 ☐

MILITARY SERVICE

Branch | From To

Rank at Discharge | Type of Discharge

If other than honorable, explain

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature | Date

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MEDICAL HISTORY QUESTIONNAIRE

NAME		SEX
ADDRESS		AGE
CITY, STATE, ZIP		PHONE #
MARITAL STATUS	NUMBER OF CHILDREN	DATE OF BIRTH
DATE OF LAST PHYISICAL EXAM	DOCTOR	

Are you bothered with or have you ever had any of the following:

YES	NO		YES	NO	
		Epilepsy			Bronchitis
		Diabetes			Cancer or Tumor
		Cardiac Disease			Chest Pains
		Arthritis			Ear Trouble
		Amputated limb or total loss of use			Eye Trouble
		Loss of Sight			Fainting or Dizzy
		Disability from Polio			Frequent Colds
		Cerebral Palsy			Hay Fever
		Multiple Sclerosis			Headaches
		Parkinson's Disease			Hearing Difficulty
		Stroke			Frequent Nose Bleed
		Tuberculosis			Ringing in Ears
		Chronic Lung Disease			Hole in Eardrum
		Psychoneurotic Disability			Hemorrhoids
		Hemophilia			Hernia
		Chronic Osteomyelitis			High Blood Pressure
		Ankylosis of Joints			Hoarseness
		Hyperinsulisim			Kidney Trouble
		Muscular Dystrophy			Nervous Breakdown
		Arteriosclerosis			Numbness in Body Parts
		Thrombophlebitis			Persistent Cough
		Varicose Veins			Pleurisy
		Heavy Metal Poisoning			Pneumonia
		Ionizing Radiation Injury			Jaundice
		Compressed Air Sequelae			Rheumatism
		Ruptured Intervertebral Disc			Skin Disorder
		Hodgkin Disease			Sore Throat
		Brain Damage			Head Injury
		Deafeness			Knee Problems
		Spinal Fusion			Neck Problems
		Mental Retardation			Trick Shoulder, knee, elbow
		Anemic Condition			Locking Knee
		Vertigo			

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MEDICAL HISTORY QUESTIONNAIRE (continued)

YES	*NO*	
		Do your feet give you trouble when you walk or stand for long periods of time?
		Have you ever injured or had trouble with your back?
		Have you ever worn a back brace or support?
		Have you ever been a patient in a hospital or clinic?
		Were you ever in the hospital for nervous trouble?
		Have you ever been hospitalized, treated, or counseled for use of alcohol, drugs, or other chemicals?
		Have you ever been advised or do you contemplate having an operation?
		Have you ever had surgery?
		Has your weight changed more than fifteen (15) pounds in the last two (2) years?
		Have you ever developed an allergy or sensitivity to chemicals, dust, sunlight, or other allergens?
		Have you ever had any serious illness not mentioned before?
		Have you ever been refused employment because of your health?
		Have you ever received or is there a claim for Worker's Compensation?
		Have you had any injury or condition not mentioned before?

How much time lost in the last five (5) years because of injury or illness?____________________

Have you ever had an injury, illness, or condition that caused you to miss more than three(3) consecutive work days?_______ If yes, what injury, illness, or condition?___________________________________

____

When did you last consult a physician?______________ Why?___________________________

When was you last chest X-Ray?___________________ Year?__________________________

Have you had your hearing tested?__________ When?___________ Why?_______________

Are you currently on medication?________ What?___________________________________

Are you allergic to anything?________ What?____

REMARKS OR EXPLANATIONS TO YES ANSWERS:

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SECOND INJURY FUND – Employee Medical History Questionnaire

Please answer the following question s by circling either YES or NO.

FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN FORFEITURE OF YOUR WORKER' COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

1. Have you ever had a disease or disability arising from your occupation? YES NO
   If YES, please explain: ______________________
2. Have you ever received workers' compensation benefits for an injury that occurred at work?
   YES NO If YES, when? ______________________
3. How long were you on compensation? ______________________
   Name of employer:______________________
   Nature of injury:______________________
4. Have you ever been rejected for employment, insurance, or military service because of you health?
   YES NO If YES, please explain:______________________
   ____
5. Have you ever had back trouble or injury to your back, head, or neck? YES NO
   If YES, please explain: ______________________
6. Do you have any restrictions or limitations upon your physical activities? YES NO
   If YES, please explain: ______________________
7. What operations, accidents, broken bones, strains, or serious illnesses have you had?
   ____

Have you had any of the following? Put and "X" in the box for YES. Leave box blank for NO

	Amputation (foot, leg, arm, hand, or total loss thereof)		Communicable Disease		Hyper Tension		Psychoneurotic Disability (following treatment in a recognized institution)
	Ankylosis of Joints		Compressed Air Sequelae		Ionizing Radiation Injury		Reflex Sympathetic Dystrophy
	Arteriosclerosis		Diabetes		Kidney Disorder		Repetitive Motion Injury
	Arthritis		Dizziness		Loss of Hearing (more than 75%)		Residual Disability from Polio
	Asthma		Double Vision (Blurred Sight)		Loss of Sight (of one or both eyes or a pt. loss of uncorrected vision)		Rheumatism
	Back/Neck Problem		Emphysema		Loss of Use of Limbs		Rotator Cuff injury
	Brain Damage		Epilepsy		Mental Disorders		Ruptured Intervertebral Disc
	Bronchitis		Head Injury		Mental Retardation		Silicosis
	Cancer		Heart Condition		Multiple Sclerosis		Spinal Fusion
	Cardiac Disease		Heavy Metal Poisoning		Muscle, Ligament or Tendon Injury		Stroke
	Carpal Tunnel Syndrome		Hemophilia		Muscular Dystrophy		Sugar in Urine
	Cerebral Vascular Accident		High/Low Blood Pressure		Nervous Disorders		Surgical Removal of Intervertebral Disc
	Chronic Osteomyelitis		Hodgkin's Disease		Numbness of Extremities		Thrombophlebitis
			Hyperinsulinism		Parkinson's Disease		Thoracic Outlet Syndrome

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SECOND INJURY FUND – Employee Medical History Questionnaire (continued)

If YES, please explain: ____

____

____

____

1. Do you have any other long-term health problems or adverse physical conditions?
   YES NO

   If YES, please explain: ____

   ____

Signature: ______________________________ Date: ________________

Name Printed: ______________________________

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SIGNATURE

The information provided in this Application for Employment is true, correct, and complete. If you employ me, any misstatement or omission of fact on this application may result in my dismissal. I declare that I have had no injury, illness, or ailment other than those noted. I certify that all information is true and accurate to the nest of my knowledge. Falsification of any information could result in disqualification of Louisiana Worker's Compensation and Employment for this Company.

I understand that acceptance of an offer of employment creates no obligation upon you, the employer, to continue to employ me in the future.

____
(Today's Date)