HOCKER & SONS

Equal Opportunity Employer

55 E. COTTONWOOD RD
PO BOX 467
ARTESIA NM 88211

It is the continuing policy of the Company to provide equal opportunity to each individual in all aspects of employment or the provision of services without regard to any status protected by law, including race, color, religion, age, sex, national origin, disability, veteran status or any other non-job related factor.

PERSONAL INFORMATION

LAST NAME FIRST MIDDLE | Today's Date:

Present Address
STREET CITY STATE ZIP

Telephone Number
Social Security Number:

Are you authorized to work in the U.S.? Are you age 18 or over Yes No

Please Indicate Name & Relationship of any relatives employed by Hocker & Son's.

Have you ever been employed by Hocker & Sons: Yes No If yes, When:

Position(s) Applied For: Date Available for Employment:

Interests: Full Time Part Time Summer or Temporary Are you available for Overtime? Yes No

EDUCATION & TRAINING

	HIGH SCHOOL	COLLEGE	GRADUATE SCHOOL
Circle Highest Grade Completed	1-4	1-4	1- 4

	Name of School	Location (City & State)	Did you Graduate?	Type of Certificate Or Degree Received
High School / GED:				
Jr. College:				
College /University:				
Business:				
Tech/Trade/Other:				

SPECIAL SKILLS

Please list any specific job-related skills you may have:

EMPLOYMENT HISTORY

List Present or Most Recent Employer FIRST. *(This section Must be Completed)*

NAME OF EMPLOYER Dates of Employment (Mo./Yr.) Name/Title of Immediate Supervisor

From To

Address of Employer Reason for Leaving

Street City State Zip

Phone Number of Employer Starting Salary $Per/HR Current/Final $Per/HR

Job title and Description of duties:

May we contact this employer?

NAME OF EMPLOYER Dates of Employment (Mo./Yr.) Name/Title of Immediate Supervisor

From To

Address of Employer Reason for Leaving

Street City State Zip

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Job title and Description of duties:

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NAME OF EMPLOYER Dates of Employment (Mo./Yr.) Name/Title of Immediate Supervisor

From To

Address of Employer Reason for Leaving

Street City State Zip

Phone Number of Employer Starting Salary $ Per/HR Current/Final $Per/HR

Job title and Description of duties:

May we contact this employer?

NAME OF EMPLOYER	Dates of Employment (Mo./Yr.) From	To	Name/Title of Immediate Supervisor	
Address of Employer Street	City	State	Zip	Reason for Leaving
Phone Number of Employer	Starting Salary $ Per/HR		Current/Final $Per/HR	
Job litle and Description of duties:				
May we contact this employer?				

REFERAL SOURCE

walk In	Advertisment	Non-Employee	Internet	Other

REFERENCES

Please list three persons (other then relatives) who have known you for at least one year and who are quilified to evalute your professional abilities

Name	Organization Email Address	
Occupation	Address City, State Zip	Phone
Name	Organization Email Address	
Occupation	Address City, State Zip	Phone
Name	Organization Email Address	
Occupation	Address City, State Zip	Phone

OTHER INFORMATION

Do you have a valid drivers license? Yes No Drivers License Number: Expiration Date:

Have you ever been convicted of a felony?

If Yes,please give details of each felony: (What,where, when, and disposition) conviction will not necessarily disqualify applicant from consideration)

Can you perform the essential functions of the job for which you are applying with or without reasonable accommodation? Yes No

I certify that the information provided on this application for employment is true and complete to the best of my knowledge and understand that false information or significant omission of facts may disqualify me from further consideration for employment or may result in termination if discovered at a later date.I hereby give my permission to the Company,or its agent, to verify,at any time, information pertaining to my application for employment, including,but not limited to, felony,credit,and driving records,and authorize persons,schools,current and previous employers and organizations to confidentially provide pertinent information which may be requested. I hereby agree to hold harmless any individual,company,business entity, institution or government agency from all liability with regard to furnishing that information to Hocker & Sons.I hereby agree to release and hold Hocker Sons harmless from all liability with respect to the receipt of such information.In the event of my employment,I acknowledge that it may be necessary for the Company to conduct workplace investigations and obtain consumer reports or investigative consumer reports during my employment, and I hereby consent to the same.I agree in the event and in consideration of my employment, to conform to all procedures and polides of the Company. I understand that in the event I am employed by the Company, any employment is at will and can be terminated for any or no reason at any time at the discretion of either the Company or myself. I understand that no express or implied promise or guarantee to the contrary with regard to duration or terms of employment, wages or benefits is binding upon the Company unless made in writing and duly executed by the Company's President and is clearly and spedfically identified as an employment contract or employment agreement.

I fully understand that my refusal to either sign this form or submit to and cooperate in any drug and alcohol testing shall eliminate me from consideration for employment with the Company.

Signature of Applicant______________________________ Date_____________________

In accordance with the Immigration Reform and Control Act of 1986, the Company hires only United States Citizens and aliens lawfully authorized to work in the United States.

All new employees hired after June 1, 1987 are required to complete and sign any forms designated by the immigration Naturalization Service and to
provide supporting documentation to certify eligibility for employment.

Conditional lob offer & Medical Review

Based on qualifications presented on your application form and/or in your job interview,you are hereby offered a job with Hocker Construction conditional upon submitting to our standard medical review and the verification of your answers to the following questions. Your job cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job,or you present a hazard to yourself or others. False or misleading statements are also grounds for rescinding this offer. Please note that workers' compensation benefits in some states may also be affected by false or misleading information. This form must be accurate and complete for us to process. This information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with the Americans with Disabilities Act. This offer is valid only if the back of this page is signed by a company representative.

Health and Safety

1.) ____Yes ____No Have you had any injuries on the job?

If yes, please describe:

a) date of injury ____________________

b) employer ____________________

c) body part affected ____________________

d) cause ____________________

e) amount of lost time ____________________

f) any permanent disability(%) ____________________

g) was workers' comp claim filed? ____________________

(If more than one injury, please attach an additional sheet.)

2. ____Yes ____No **Do you have or have you had other injuries or illnesses not on the job (home, auto, sports, hunting, etc.) that have resulted in hospitalization, surgery or lost time in which would affect your ability to perform the essential functions of this position with or without reasonable accommodation?**

If yes, please describe:

a) date of injury/ illness ____________________

b) body part affected ____________________

c) cause ____________________

d) days in hospital ____________________

e) days lost work time ____________________

f) have you recovered? ____________________

(If more than one, please attach an additional sheet.)

3. ____ Yes ____No Are you taking any long term (more than 30 days) prescribed medications which would affect your ability to perform the essential functions of this position with or without reasonable accommodations?

If yes, please describe:

a) type of medication____________________

b) purpose____________________

c) side effects____________________

(If more than one, please attach an additional sheet.)

Comments:

Affirmation and Authorization

I hereby affirm that the information on this form is true and correct, and that there are no omissions, false information or misrepresentation of facts. authorize any physician, medical facility,law enforcement agency,administrator,state agency, institution, information service bureau, insurance company or employer contacted by Hocker & Sons or an agent of this company to furnish or verify workers' compensation information and medical records.

Today's Date: ______________________________

Signature: ______________________________