EMPLOYMENT APPLICATION

Name:		Date:
Address:		SSN:
City:	State:	Zip:
Home phone: ( )	Message: ( )	

GENERAL INFORMATION

Position applied for: _____ Full-time ☐ Part-time ☐ On-call ☐

Where did you learn about the position you are applying for? _____

Have you worked or applied here before?…… ..Yes ☐ No ☐

When would you be available to start work? _____

Are there any times/days you are not available to work?……Yes ☐ No ☐

If yes, what are they? _____

Are you a US citizen or can you provide proof of your eligibility to work in the US?…… Yes ☐ No ☐

Are you 18 years of age or older?…….. …… Yes ☐ No ☐

Do you have any friends/relatives working here?…….. Yes ☐ No ☐

Do you have a valid driver's license? ……..Yes ☐ No ☐

Ever Suspended?…… Yes ☐ No ☐

Do you have a minimum of 3 years driving experience?…….. Yes ☐ No ☐

Do you have arrests/convictions that may inhibit your passing a criminal records check?… .Yes ☐ No ☐

Are you able to perform the essential functions of the job for which you are applying, either with or without reasonable accommodation?……Yes ☐ No ☐

If accommodation is necessary, please describe that accommodation:

(Note: We comply with the ADA and consider reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions).

EDUCATION

Name and location of high school? ☐ Diploma ☐ GED

List name and location of college or university	Major	Years Attended	Degree or Diploma

Please list additional licenses and credentials.

List other experience, training or skills that qualify you for this position.

EMPLOYMENT HISTORY

Name of Employer:	Circle One: Full-time Part-time
Address:	City: State: Zip:
Job Title:	Dates Of Employment: __/__/__ - __/__/__
Reason for Leaving:	Salary: Begin: End:
Specific Duties:	
Supervisor's Name:	Contact number: ( )

Name of Employer:	Circle One: Full-time Part-time
Address:	City: State: Zip:
Job Title:	Dates Of Employment: __/__/__ - __/__/__
Reason for Leaving:	Salary: Begin: End:
Specific Duties:	
Supervisor's Name:	Contact number: ( )

Name of Employer:	Circle One: Full-time Part-time
Address:	City: State: Zip:
Job Title:	Dates Of Employment: __/__/__ - __/__/__
Reason for Leaving:	Salary: Begin: End:
Specific Duties:	
Supervisor's Name:	Contact number: ( )

Please complete if less than five years work history is listed above.

Date	Employer Name and Contact Number	Position

REFERENCES

Please provide the names, addresses, and telephone numbers of at least three references not related to you.

			( )	
Name			Phone	Relationship
City	State	Zip Code		Years Known

			( )	
Name			Phone	Relationship
City	State	Zip Code		Years Known

			( )	
Name			Phone	Relationship
City	State	Zip Code		Years Known

In case of an emergency, please notify:

			( )	
Name			Phone	Relationship
City	State	Zip Code		

PLEASE READ EACH STATEMENT CAREFULLY BEFORE SIGNING

I certify that all information provided in this employment application is true and complete. I understand that any false information or omission may disqualify me from further consideration for employment and may result in my dismissal if discovered at a later date.

I authorize and agree to cooperate in a thorough investigation of all statements made herein and other matters relating to my background and qualifications. I understand that any investigation conducted may include a request for employment and educational history, driving records, and criminal history. I authorize any person, school, current and former employer, and any other organization or agency to provide information relevant to such investigation and I hereby release all persons and corporations requesting or supplying information pursuant to such investigation from all liability or responsibility to me for doing so. I understand that I have the right to make a written request within a reasonable period of time for a complete disclosure of the nature and scope of any investigation.

I UNDERSTAND THAT THIS APPLICATION OR SUBSEQUENT EMPLOYMENT DOES NOT CREATE A CONTRACT OF EMPLOYMENT NOR GUARANTEE EMPLOYMENT FOR ANY DEFINITE PERIOD OF TIME. IF EMPLOYED, I UNDERSTAND THAT I HAVE BEEN HIRED AT THE WILL OF THE EMPLOYER AND MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME, WITH OR WITHOUT CAUSE AND WITH OR WITHOUT NOTICE.

I have read, understand, and by my signature consent to these statements.

Signature Date

Name: Date:

Position applied for: Date of birth:

Applicant EEO or Affirmative Action Information

COMPLETION OF THIS FORM IS VOLUNTARY AND IN NO WAY AFFECTS THE DECISION REGARDING YOUR APPLICATION FOR EMPLOYMENT. THIS FORM IS CONFIDENTIAL AND WILL BE MAINTAINED SEPARATELY FROM YOUR APPLICATION FORM. PLEASE PRINT
SOASTC is an AA/EEO organization. This information is optional, you may decline to fill out this section without adverse effect or probability of employment. We agree to provide equal employment opportunity to all qualified applicants without regard to race, color, religion, national origin, sex, age, veteran status, disability or any other characteristic protected by applicable local, state, or federal civil rights law. Various agencies of the government require employers to invite applicants to identify themselves as indicated by the questions above.

What is your race/ethnic origin?

- ☐ Hispanic or Latino
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Two or More Races

What is your sex?

- ☐ Female
- ☐ Male

Are you a Vietnam Era Veteran? Yes ☐ No ☐

A person who served on active duty for a period of more than 180 days any part of which occurred between 8/5/64 and 5/7/75, and was discharged or released there from with other than a dishonorable discharge or for a service connected disability.

Are you a disabled veteran? Yes ☐ No ☐

A person entitled to disability compensation under laws administered by the Veterans Administration for disability rated at 30% or more, or a person whose discharge or release from active duty was for a disability incurred or aggravated in the line of duty.

Do you have a mental or physical disability? Yes ☐ No ☐

A person who has a mental or physical impairment that substantially limits one or more major life activities, who have a record of such impairment, or who is regarded as having such impairment.

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.