LARRY SMITH INC.

APPLICATION FOR EMPLOYMENT

WE ARE AN EQUAL OPPORTUNITY EMPLOYER. ALL APPLICANTS ARE CONSIDERED FOR EMPLOYMENT BASED ON THEIR QUALIFICATIONS, WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, AGE, DISABILITY, HANDICAP, MARITAL OR VETERAN STATUS.

DATE OF APPLICATION:_____

INTRODUCTORY INFORMATION

NAME:_____
(LAST NAME) (FIRST NAME) (MIDDLE)

ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

TELEPHONE:_____ SOCIAL SECURITY NO:_____

ARE YOU A CITIZEN OF THE U.S. OR AN ALIEN AUTHORIZED TO WORK IN THE US YES____NO____

MARITAL STATUS: SINGLE_____ MARRIED_____
DIVORCED_____

STATE YOUR AGE: _____ AND DATE OF BIRTH:_____

POSITION DESIRED:_____ DATE YOU CAN START WORK:_____

WAGE DESIRED:_____PER_____

ARE YOU AVAILABLE FOR FULL TIME WORK?_____ PART TIME WORK?_____

ARE YOU WILLING TO WORK ANY SHIFT?_____ IF NO, THEN WHAT HOURS?_____

WHAT DAYS OF THE WEEK ARE YOU NOT AVAILABLE FOR WORK?_____

ARE YOU WILLING TO TRAVEL?_____ TO RELOCATE?_____

HAVE YOU EVER BEEN EMPLOYED BY THIS COMPANY BEFORE?_____
IF YES, STATE WHEN AND THE POSITION HELD_____
WHY DID YOU LEAVE?_____

DO YOU KNOW ANYONE WHO WORKS HERE?_____ WHO?_____

WHO REFERRED YOU TO THE COMPANY?_____

EDUCATION AND TRAINING

DID YOU COMPLETE HIGH SCHOOL?_____ ACQUIRE A G.E.D.?_____

IF NOT, YOUR HIGHEST GRADE COMPLETED WAS:_____

NAME AND LOCATION OF LAST SCHOOL ATTENDED:_____

JOB RELATED COURSES COMPLETED OR OTHER SKILLS
ACQUIRED:_____

COLLEGE OR GRADUATE SCHOOL
COMPLETED:_____

AREAS OF STUDY:_____

DEGREES RECEIVED:_____

LIST TRADE OR TECHNICAL SCHOOLS ATTENDED AND YEARS COMPLETED:
_____

EMPLOYMENT HISTORY

PRESENT OR LAST EMPLOYER
NAME:_____
ADDRESS:_____
TELEPHONE NO.:_____TYPE OF BUSINESS:_____
START DATE:_____DEPARTURE DATE:_____
STARTING POSITION:_____STARTING PAY:_____
FINAL POSITION:_____FINAL
PAY:_____
NAME AND TITLE OF IMMEDIATE SUPERVISOR:_____
DESCRIPTION OF YOUR RESPONSIBILITIES:_____
REASON FOR LEAVING:_____
IF YOU ARE STILL EMPLOYED, MAY WE CONTACT THIS EMPLOYER AT THIS TIME?_____

NEXT PREVIOUS EMPLOYER
NAME:_____
ADDRESS:_____
TELEPHONE:_____TYPE OF BUSINESS:_____
DATE HIRED:_____DEPARTURE DATE:_____
STARTING POSITION:_____STARTING PAY:_____
FINAL POSITION:_____FINAL
PAY:_____
NAME AND TITLE OF IMMEDIATE SUPERVISOR:_____
DESCRIPTION OF YOUR RESPONSIBILITIES:_____
REASON FOR LEAVING:_____

NEXT PREVIOUS EMPLOYER
NAME:_____ PHONE:_____
ADDRESS:_____
TYPE OF WORK:_____REASON FOR LEAVING:_____

YEARS AND MONTHS WORKED: _____FINAL PAY: _____
PLEASE CONTINUE LISTING PRIOR EMPLOYMENT
_____
_____
_____

HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? _____
STATE THE NAME AND WHERE YOU WERE EMPLOYED: _____

ARE YOU CURRENTLY SUBJECT TO AN AGREEMENT WITH ANY EMPLOYER UNDER WHICH YOU HAVE AGREED NOT TO WORK FOR A COMPETITOR OF THAT EMPLOYER? _____
IF YES, EXPLAIN: _____

HAVE YOU EVER BEEN DISCHARGED OR ASKED TO RESIGN BY AN EMPLOYER? _____
IF YES, EXPLAIN: _____

MILITARY SERVICE

HAVE YOU EVER SERVED IN THE UNITED STATES ARMED FORCES? _____

STATE THE BRANCH AND LIST ANY JOB-RELATED SKILLS YOU ACQUIRED OR DUTIES YOU PERFORMED: _____
_____

MISCELLANEOUS INFORMATION

HAVE YOU EVER BEEN CONVICTED OF A CRIME, OTHER THAN MINOR TRAFFIC OFFENSES? _____
IF YES, EXPLAIN: _____

A RECORD OF CRIMINAL CONVICTION DOES NOT NECESSARILY SERVE AS A BAR TO EMPLOYMENT.

THE POSITION YOU ARE APPLYING FOR MAY REQUIRE DRIVING COMPANY VEHICLES. PLEASE LIST YOUR CURRENT DRIVERS LICENSE NUMBER INCLUDING THE STATE: _____

PLEASE LIST ANY ENDORSEMENTS ON YOUR LICENSE (CDL, CLASS, ETC.)_____

HAS YOUR DRIVERS LICENSE EVER BEEN SUSPENDED OR REVOKED? _____
IF YES, EXPLAIN: _____

LIST ANY CITATIONS YOU HAVE RECEIVED IN THE LAST FIVE YEARS: _____
_____

LIST ANY ACCIDENTS YOU HAD IN THE LAST FIVE YEARS: _____
_____

REFERENCES

PROVIDE NAME, ADDRESS, PHONE OF THREE UNRELATED CHARACTER REFERENCES:
_____
_____
_____

PLEASE READ THE FOLLOWING PARAGRAPHS CAREFULLY

I CERTIFY THAT ALL THE INFORMATION I HAVE SUPPLIED ON THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND THAT I HAVE NOT KNOWINGLY WITHHELD ANY INFORMATION WHICH, IF KNOWN TO THE COMPANY , WOULD AFFECT MY APPLICATION UNFAVORABLY. I UNDERSTAND THAT ANY FALSE, MISLEADING AND/OR INCOMPLETE STATEMENTS ON THIS APPLICATION AND/OR IN ANY INTERVIEW, CONSTITUTE SUFFICIENT CAUSE FOR THE COMPANY NOT TO EMPLOY ME, AND IF EMPLOYED, TO TERMINATE MY EMPLOYMENT.

I AUTHORIZE AN INVESTIGATION TO BE CONDUCTED CONCERNING ALL OF THE INFORMATION I HAVE SUPPLIED ON THIS APPLICATION, AND ALL OTHER INFORMATION WHICH THE COMPANY DEEMS TO BE RELEVANT TO MY QUALIFICATIONS FOR EMPLOYMENT. I FURTHER AUTHORIZE MY PRESENT EMPLOYER, ANY FORMER EMPLOYER, EDUCATIONAL INSTITUTION, LAW ENFORCEMENT ORGANIZATION, CONSUMER REPORTING AGENCY, PROFESSIONAL OR PERSONAL REFERENCE OR OTHER APPROPRIATE SOURCE OR INDIVIDUAL TO PROVIDE ALL INFORMATION THAT IS REQUESTED IN CONNECTION WITH SUCH INVESTIGATION. I UNDERSTAND THAT IF AN INVESTIGATIVE REPORT IS REQUESTED FROM A CONSUMER REPORTING AGENCY, I HAVE THE RIGHT TO MAKE A WRITTEN REQUEST WITHIN A REASONABLE PERIOD OF TIME FOR A COMPLETE AND ACCURATE DISCLOSURE OF THE NATURE AND SCOPE OF THE INVESTIGATION REQUESTED. I RELEASE THE COMPANY AND ALL NAMED AND UNNAMED SOURCES FROM ANY AND ALL LIABILITY WHICH MAY RESULT FROM FURNISHING INFORMATION CONCERNING ME.

I AGREE TO TAKE ANY LAWFUL EXAMINATION OR TEST, INCLUDING ANY DRUG AND/OR ALCOHOL TEST, REQUIRED BY THE COMPANY AS A CONDITION OF MY BEING HIRED, OR IF I AM HIRED, AS A CONDITION OF MY CONTINUED EMPLOYMENT. I FURTHER AGREE THAT MY REFUSAL TO TAKE ANY SUCH LAWFUL EXAMINATION OR TEST WILL CONSTITUTE SUFFICIENT CAUSE FOR THE COMPANY NOT TO EMPLOY ME, OR IF I AM EMPLOYED, TO TERMINATE MY EMPLOYMENT.

I RELEASE THE COMPANY AND ALL OTHER NAMED OR UNNAMED SOURCES FROM ANY AND ALL LIABILITY WHICH MAY RESULT FROM ANY LAWFUL EXAMINATION OR TEST.

IF I AM EMPLOYED, I AGREE THAT IN CONSIDERATION FOR MY EMPLOYMENT, I WILL CONFORM TO THE RULES AND REGULATIONS OF THE COMPANY. I UNDERSTAND THAT THOSE RULES AND REGULATIONS MAY BE ALTERED, AMENDED OR REPEALED BY THE COMPANY AT ANY TIME, AT THE COMPANY'S SOLE OPTION AND WITHOUT ANY PRIOR NOTICE TO EMPLOYEES.

I ACKNOWLEDGE THAT IF I AM EMPLOYED, MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED AT ANY TIME, WITH OR WITHOUT CAUSE OR NOTICE, AT THE OPTION OF EITHER THE COMPANY OR MYSELF. I UNDERSTAND THAT NO REPRESENTATIVE OF THE COMPANY HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIED PERIOD OF TIME.

_____

SIGNATURE OF APPLICANT DATE

_____

WITNESS DATE

POST - OFFER MEDICAL QUESTIONNAIRE

AFTER RECEIVING AN OFFER OF EMPLOYMENT AND BEING ADVISED OF THE ESSENTIAL FUNCTIONS OF THE POSITION OFFERED, ALL INDIVIDUALS MUST COMPLETE THIS QUESTIONNAIRE BEFORE THEY WILL BE PERMITTED TO START WORK. UPON COMPLETION, THE QUESTIONNAIRE WILL BE MAINTAINED IN A SEPARATE MEDICAL FILE AND THE INFORMATION CONTAINED ON IT KEPT CONFIDENTIAL AND DISCLOSED ONLY TO THOSE WHO NEED TO KNOW THE INFORMATION FOR THE PURPOSE OF ACCOMMODATING A DISABILITY OR FOR HEALTH AND SAFETY REASONS.

NAME:_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____
(STREET) (CITY STATE ZIP

TELEPHONE :_____ SOCIAL SECURITY NO._____

DATE OF BIRTH :_____ POSITION OFFERED :_____

IDENTIFY ANY MENTAL OR PHYSICAL CONDITIONS WHICH IN ANY MAY LIMIT YOUR ABILITY TO PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION YOU HAVE BEEN OFFERED:_____
_____

HOW LONG HAS THE CONDITIONS EXISTED ?_____

DESCRIBE YOUR LIMITATIONS: _____
_____

WILL YOU REQUIRE TIME OFF WORK TO RECEIVE MEDICAL CARE OR TREATMENT FOR THE CONDITION (S) :_____ HOW OFTEN ?_____

HOW OFTEN AND FOR HOW LONG DO YOU EXPECT TO BE PERIODICALLY TOTALLY DISABLED AS A RESULT OF THE CONDITION (S) ?_____

IS YOUR CONDITION(S) EXPECTED TO IMPROVE, WORSEN OR REMAIN THE SAME?_____

LIST NAMES, ADDRESSES AND TELEPHONE NUMBERS OF EACH PHYSICIAN FROM WHOM YOU RECEIVE TREATMENT FOR YOUR CONDITION (S):_____
_____
_____

<u>OTHER THAN THOSE CONDITIONS LISTED ABOVE</u>;
WITHIN THE LAST TWO YEARS, HAVE YOU BEEN UNDER THE CARE OR TREATMENT OF A PHYSICIAN FOR ANY PHYSICAL OR MENTAL CONDITIONS ?_____

IF YES, IDENTIFY THE CONDITION (S):_____
_____

ARE YOU CURRENTLY RECEIVING TREATMENT OR CARE FOR THE CONDITION (S):_____

LIST ANY RESTRICTIONS DUE TO THE CONDITION (S):_____
_____

HISTORY OF WORKERS' COMPENSATION

IDENTIFY EACH INJURY OR ILLNESS FOR WHICH YOU HAVE RECEIVED WORKERS' COMPENSATION, INCLUDING, THE NAME OF THE EMPLOYER, AMOUNT OF TIME LOST FROM WORK, AND ALL RESTRICTIONS:_____
_____
_____
_____
_____
_____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICINES ON A REGULAR BASIS ?_____ IF YES, LIST EACH MEDICINE AND SIDE EFFECTS:
_____
_____
_____

CERTIFICATION AND RELEASE

I CERTIFY THAT ALL OF THE ANSWERS I HAVE GIVEN ON THIS QUESTIONNAIRE ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE, MISLEADING AND/OR INCOMPLETE ANSWER CONSTITUTES SUFFICIENT CAUSE FOR THE COMPANY TO TERMINATE MY EMPLOYMENT.

I AUTHORIZE ANY PHYSICIAN I HAVE NAMED IN THIS QUESTIONNAIRE TO RELEASE TO THE COMPANY, OR ITS DESIGNATED AGENTS, ALL MEDICAL RECORDS AND INFORMATION HE OR SHE HAS, AND OPINIONS HE OR SHE HOLDS, WHICH IN ANY WAY RELATE TO MY PHYSICAL OR MENTAL ABILITY TO PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION I HAVE BEEN OFFERED.

_____
SIGNATURE OF APPLICANT DATE

_____
WITNESS DATE

APPLICANT DATA RECORD

PLEASE CHECK CORRECT RESPONSE WHERE APPLICABLE

APPLICANTS ARE CONSIDERED FOR ALL POSITIONS, AND EMPLOYEES ARE TREATED DURING EMPLOYMENT WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, AGE, DISABILITY, HANDICAP, MARITAL OR VETERAN STATUS.

AS EMPLOYERS / GOVERNMENT CONTRACTORS, WE COMPLY WITH GOVERNMENT REGULATIONS AND AFFIRMATIVE ACTION RESPONSIBILITIES.

SOLELY TO HELP US COMPLY WITH GOVERNMENT RECORD KEEPING, REPORTING AND OTHER LEGAL REQUIREMENTS, PLEASE FILL OUT THE APPLICANT DATA RECORD. WE APPRECIATE YOUR COOPERATION.

THIS DATA IS FOR PERIODIC GOVERNMENT REPORTING AND WILL BE KEPT IN A CONFIDENTIAL FILE.

POSITION APPLIED FOR:_____

HOW WERE YOU REFERRED?_____

NAME:_____SOCIAL SECURITY NO. :_____

ADDRESS:_____

SEX: M_____ F_____

RACE / ETHNIC GROUP _____WHITE _____BLACK
_____HISPANIC _____ASIAN
_____ALASKAN _____AMERICAN INDIAN
_____PACIFIC ISLANDER

VETERAN / HANDICAPPED _____VIETNAM ERA VETERAN
_____DISABLED VETERAN
_____HANDICAPPED INDIVIDUAL