

O.H.I. Co.

P.O. BOX 622
STOCKTON, CA 95201
(209) 466-8921

APPLICATION FOR EMPLOYMENT

AN EQUAL OPPORTUNITY EMPLOYER M/F

PLEASE PRINT (APPLICANTS MUST BE 18 YEARS OLD)

DATE: _____

NAME:	LAST	FIRST	MIDDLE/MAIDEN	SOCIAL SECURITY NO:
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ADDRESS:	PHONE NO.:
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THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967 PROHIBITS DISCRIMINATION ON THE BASIS OF THOSE BETWEEN THE AGES OF 40 AND 70.

DATE OF BIRTH: _____ U.S. CITIZEN YES NO IF NOT, REG. CARD NO.: _____

FRIENDS/RELATIVES WITH COMPANY: _____
(IF YES, GIVE NAME AND RELATIONSHIP)

HIGH SCHOOL ATTENDED:	YRS. COMPLETED:
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COLLEGE OR TECHNICAL SCHOOL:	YRS. COMPLETED:	MAJOR:
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OTHER TRAINING: _____
(TRADE, BUSINESS, MILITARY, CORRESPONDENCE, ETC. INCLUDE SCHOOL AND IF GRADUATED)

HAVE YOU EVER SERVED IN THE MILITARY YES NO BRANCH: _____

CURRENT STATUS:	DUTIES WHILE ACTIVE:
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POSITION YOU ARE APPLYING FOR:

FORMAN MECHANIC LAYEROUT TEMPLATE MAKER MAINTENANCE FITTER

WELDER BURNER MACHINE OPERATOR FORKLIFT DRIVER HELPER _____

INDICATE SHIFTS YOU ARE WILLING TO WORK: DAY SWING GRAVEYARD ANY

QUALIFICATIONS:

WELDING:	YRS. EXP.	CRANES:	YRS. EXP.
INNERSHIELD:		CAB OPERATED	
GAS METAL ARC (MIG)		PENDANT OR HAND OPERATED	
SUBMERGED ARC		LIFT TRUCKS:	YRS. EXP
GAS TUNGSEN (TIG)		SIZE:	
OTHER:		SIZE:	
ARE YOU CURRENTLY CERTIFIED	<input type="checkbox"/> YES <input type="checkbox"/> NO	PRODUCTION MACH.	SET-UP (YES OR NO) YRS. EXP.
BURNER:	YRS. EXP.		
HAND TORCH			
PLASMA			
TRACK			
ELECTRIC EYE			

DO YOU READ BLUEPRINTS YES NO HAVE YOU HAD ON THE JOB TRAINING YES NO

HAVE YOU HAD APPRENTICESHIP TRAINING YES NO PLEASE EXPLAIN: _____

FORMER EMPLOYEE OF THIS COMPANY YES NO

IF YES, FROM: _____ TO: _____ DEPT. _____

PAST EMPLOYMENT RECORD
(START WITH MOST RECENT POSITION)

EMPLOYER AND ADDRESS:	FROM	MO.	YR.	POSITION/DUTIES/RATE OF PAY	REASON FOR LEAVING
	TO				
EMPLOYER AND ADDRESS:	FROM	MO.	YR.	POSITION/DUTIES/RATE OF PAY	REASON FOR LEAVING
	TO				
EMPLOYER AND ADDRESS:	FROM	MO.	YR.	POSITION/DUTIES/RATE OF PAY	REASON FOR LEAVING
	TO	MO.	YR.		
EMPLOYER AND ADDRESS:	FROM	MO.	YR.	POSITION/DUTIES/RATE OF PAY	REASON FOR LEAVING
	TO				
EMPLOYER AND ADDRESS:	FROM	MO.	YR.	POSITION/DUTIES/RATE OF PAY	REASON FOR LEAVING
	TO				

DESCRIBE ANY PHYSICAL DEFECTS, MAJOR ILLNESS OR INJURY WHICH MAY AFFECT WORK PERFORMANCE ON THE JOB APPLIED FOR OR LIMIT YOUR ABILITY TO PERFORM OTHER TASKS _____

WHAT CAN WE DO TO ACCOMODATE _____

APPLICANT MAY BE REQUIRED TO SUBMIT TO A PHYSICAL EXAMINATION AS A CONDITION OF EMPLOYMENT

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME: _____ ADDRESS: _____ PHONE: _____

HAVE YOU EVER BEEN CONVICTED FOR OTHER THAN MINOR TRAFFIC VIOLATIONS YES NO

IF YES, PLEASE EXPLAIN: _____

IT IS UNDERSTOOD AND AGREED THAT ANY MISREPRESENTATION BY ME IN THIS APPLICATION WILL BE SUFFICIENT CAUSE FOR CANCELANON OF THE APPLICATION AND/OR FOR SEPARATION FROM THE COMPANY'S SERVICE IF I HAVE BEEN EMPLOYED. I HEREBY AUTHORIZE THE COMPANY TO MAKE WHATEVER INVESTIGATION IT DEEMS NECESSARY TO VERIFY OR CHECK ON THE INFORMATION. GIVEN ABOVE.

SIGNATURE: _____

WE APPRECIATE YOUR INTEREST AND TIME YOU HAVE TAKEN TO PREPARE THIS APPLICATION

O.H.I. Co.

P.O. BOX 622, STOCKTON, CA 95201

VERIFICATION OF PREVIOUS EMPLOYMENT

APPLICANT: Please sign your name on the signature line only, authorizing O.H.I. Co. to check all prior employers.

Name of Past Employer and Address:

Name _____ Street _____

City _____ State _____ Zip _____

Supervisor _____ Phone _____

I, Name _____ SS No _____
Last First Middle

worked for you from _____ to _____ as a _____
Mo. Year Mo. Year Position Held

Reason for Leaving _____

I hereby authorize you to furnish O.H.I. Co. the information requested below.

APPLICANT'S SIGNATURE: _____

The below named person has applied to us for employment and has given us the following information regarding employment with you. Please verify the following:

APPLICANT'S NAME _____ SS No. _____

POSITION HELD _____ SALARY _____

DATES OF EMPLOYMENT _____ REASON FOR LEAVING _____

JOB PERFORMANCE CRITERIA	OUTSTANDING	ABOVE AVERAGE	ACCEPTABLE	MARGINAL	UNACCEPTABLE	COMMENTS
ABILITY TO LEARN						
ATTENDANCE/RELIABILITY						
COOPERATION						
QUALITY OF WORK						
SAFETY HABITS						
USE OF WORKING TIME						

Did he/she receive workmen's compensation due to an on-the-job injury Yes No

Date of injury _____ Time lost from _____ to _____

Nature of injury _____ Physician's Name _____

Amount of compensation paid _____ Temp. Indemnity _____ Perm. Disability _____

Your Insurance Carrier _____ Address _____

Firm Name _____ By _____ Phone _____ Date _____