



# APPLICATION FOR EMPLOYMENT

Please fill out completely

If not filled out completely you **will not be considered for employment.**

*Purcell, OK 73080*

Position applied for PLEASE PRINT _____	Date Available / Date Applied _____
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Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Street Address _____	Are you over the age of 18? _____ Yes _____ No
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City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone Number \_\_\_\_\_

Do you have \_\_\_\_\_ No Do you have \_\_\_\_\_ No State Licensed License Number Class  
Reliable \_\_\_\_\_ Yes a valid driver's  
Transportation? \_\_\_\_\_ Yes license? \_\_\_\_\_ Yes

<b>PREVIOUS EMPLOYMENT RECORD</b>	<b>SOCIAL SECURITY #:</b>
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Have you ever worked for HWD or Akerman Construction \_\_\_\_\_ If No how did you hear about us?  
\_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes Which Company? \_\_\_\_\_ Year \_\_\_\_\_

**NAME AND ADDRESS OF LAST 3 EMPLOYERS Begin with most recent**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Position Held \_\_\_\_\_ Date Employment Began \_\_\_\_\_  
Address \_\_\_\_\_ Rig Size \_\_\_\_\_ Date Employment Ended \_\_\_\_\_  
Reason For Leaving \_\_\_\_\_ Beginning pay rate \_\_\_\_\_ Ending pay rate \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Position Held \_\_\_\_\_ Date Employment Began \_\_\_\_\_  
Address \_\_\_\_\_ Rig Size \_\_\_\_\_ Date Employment Ended \_\_\_\_\_  
Reason For Leaving \_\_\_\_\_ Beginning pay rate \_\_\_\_\_ Ending pay rate \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Position Held \_\_\_\_\_ Date Employment Began \_\_\_\_\_  
Address \_\_\_\_\_ Rig Size \_\_\_\_\_ Date Employment Ended \_\_\_\_\_  
Reason For Leaving \_\_\_\_\_ Beginning pay rate \_\_\_\_\_ Ending pay rate \_\_\_\_\_

<b>EDUCATION—HIGHEST GRADE COMPLETED</b>
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High School Grade Completed \_\_\_\_\_ College / University Years Completed \_\_\_\_\_

<b>CERTIFICATES—PLEASE ATTACH COPIES</b>
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Applicants Signature \_\_\_\_\_

## Occupational Health Confidential Pre- Placement Health Assessment

*PERSONAL INFORMATION*

Employee Full Name \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ Home Phone Number \_\_\_\_\_

*FAMILY HEALTH HISTORY*

Relation	Age	Health ( If Deceased—age and cause)	Check if any near Relative Has/Had
Father			____ Asthma/Allergies ____ Cancer
Mother			____ Diabetes ____ Heart Disease
Sisters			____ Neurological ____ Strokes
Brothers			Disorders or Epilepsy
Children			____ Blood Disorders ____ Kidney Disease
			____ Mental Disorders ____ High Blood Pressure

*PERSONAL HEALTH HISTORY*

Are you Currently Under a Doctors Care? \_\_\_\_ Yes \_\_\_\_ No If yes Explain \_\_\_\_\_

Are you Currently Taking Prescription Drugs ? \_\_\_\_ Yes \_\_\_\_ No If yes Explain \_\_\_\_\_

Have you ever had or do you now have any problems related to:

	Yes	No		Yes	No	Yes	No
Eye of Vision Defects	_____	_____	Lungs, Pneumonia	_____	_____	Back Pain	_____
Ear of Hearing Defects	_____	_____	Rheumatic Fever	_____	_____	Varicose Veins, Hemorrhoids	_____
Frequent Headaches	_____	_____	Shortness of Breath	_____	_____	Anemia, Blood Disorder	_____
Dizzy Spells	_____	_____	Swelling of Ankles	_____	_____	Diabetes	_____
Epilepsy, Convulsions	_____	_____	Heart Trouble	_____	_____	Skin Trouble	_____
Fainting, Paralysis	_____	_____	High Blood Pressure	_____	_____	Loss of Weight, Appetite	_____
Nose, Sinus	_____	_____	Bowel, Stomach	_____	_____	Frequent Indigestion	_____
Throat, Thyroid	_____	_____	Liver, Gallbladder	_____	_____	Kidney, Bladder	_____
Chest Pain	_____	_____	Hernia	_____	_____	Allergies	_____
Arthritis, Rheumatism	_____	_____	Fractures, Dislocations	_____	_____	Operations, Hospitalization	_____
Tobacco Consumed	_____	_____	Amount per Week _____	_____	_____	Carpal Tunnel Syndrome	_____
Alcohol Consumed	_____	_____	Amount per Week _____	_____	_____	Other Illness, Injury,	_____
						Health Compliant	_____

Please complete Next Page

Please Explain all Yes Answers \_\_\_\_\_

Have you ever Received Workers Compensation or A Disability Pension for Illness of Injury? \_\_\_\_ Yes \_\_\_\_ No

If Yes, Give Date, Type of Illness or Injury, and if any Lasting effects \_\_\_\_\_

*OCCUPATIONAL HEALTH HISTORY (LAST 3 YEARS)*

Have you been exposed to an Occupational Health Hazard in the last three years i.e. Dust, fumes, chemicals

Exposure Dates	Nature of Work	Hazard Exposure	Protected	Unprotected

I Certify that the above information is correct. I hereby authorize the examiner herein to furnish the results of this assessment to the Occupational Health. I understand that omissions or misrepresentations may result in dismissal. A photographic copy of this authorization shall be as valid as the original.

Be advised that upon signing this you are allowing HWD to perform a background check to verify that all the information giving on this form is true. If it is found that the information was not factual you will be not be considered for hire.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_