Application For Employment

Drug Free / Safety First Workplace

Name ______________________________ Social Security Number ____________

Address ______________________________

______________________________ Telephone Number ____________

City, St Zipcode ______________________________

Do you have a valid drivers license? Yes / No

If Yes what is your License Number ____________ License Class ____ License State ____

Do you have your own transportation? Yes / No

If Yes what is your Vehicle Description ____________ Tag Number ____________ Vehicle State ____

Are you legally eligible for work in the United States? Yes / No Are you 18 years or older? Yes / No

Position Applied For: ____________ Referred By: ____________

Ever applied to this company before? Yes / No If Yes, when? ____________

Date you can start: ____________ Salary Desired: ____________

Are you employed now? Yes / No If yes, may we contact your present employer? Yes / No

Are you available to work: FULL-TIME PART-TIME TEMPORARY

If you have any disabilities that would interfere with your ability to perform the job for which you have applied, please explain:

U.S. Armed Forces Yes / No If Yes, Branch ____________ Rank at Discharge ____________

Have you been convicted of a felony within the past 7 years? Yes / No If yes please explain:

(Conviction will not necessarily disqualify applicant for employment)

Please list any additional information that relates to your ability to perform the job for which you have applied, such as special training, machine operations, hobbies, languages, etc.

In case of Emergeny Notify:

Name ______________________________ Phone ____________

Address ______________________________ Relationship ____________

Education	Name and Location of School	Years Attended	Date Graduated	Subjects Studied
High School				
College				
Trade, Business or Correspondence School				

Former Employers (List below last three employers, starting with last one first) Use back of page if required

I authorized investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time without any previous notice.

Date ____________ Signature ______________________________

Health Questionnaire (Post Job Offer)

This questionnaire is not being used as the basis for deciding whether to employ you. It is solely for the purpose of providing information to the Florida Special Disability Trust Fund in appropriate cases.

Personal Information

Date:

Name: Last First Middle

Address: Street Appt.# City State ZIP

Soc. Sec. #: Sex: ☐ Male ☐ Female Date of Birth: Height: Weight:

Medical History

Do you have or have you ever had any of the following? You must answer all questions. Any yes answer must be fully explained below.

	Yes	No		Yes	No
Epilepsy	☐	☐	Arthritis	☐	☐
Diabetes	☐	☐	Allergies	☐	☐
Cardiac (Heart) Disease	☐	☐	Hemophilia	☐	☐
Marie Strumpell Disease	☐	☐	HIV Virus	☐	☐
Any Loss of Vision	☐	☐	Osteomyelitis	☐	☐
Polio	☐	☐	Stiff Joints	☐	☐
Any Amputation	☐	☐	Hypoglycemia	☐	☐
Cerebral Palsy	☐	☐	Muscular Dystrophy	☐	☐
Multiple Sclerosis	☐	☐	Thrombophlebitis	☐	☐
Parkinson's Disease	☐	☐	Herniated Intervertebral Disc	☐	☐
Vascular Circulation Disorder	☐	☐	Back Surgery	☐	☐
Cancer	☐	☐	Psychiatric or Psychological Treatment or Evaluation	☐	☐
Skin Trouble	☐	☐			

Have you ever received treatment for a back, neck or knee condition or a head injury?

Do you now or have you ever suffered from aches or pains of the back?

Have you ever had any surgery?

Do you now or have you ever had any physical disabilities, impairments or handicaps?

Have you ever had a workers' compensation injury?

Are there any questions you do not understand? If yes, which question(s)?

I understand and agree that if I am injured on the job, regardless of how minor, I am to report the injury immediately to my supervisor.

I further understand and agree that my employer's workers' compensation carrier will determine the medical facility and/or doctors I am to use.

I certify the above answers to be true and correct. I understand that any false or misleading answers to these questions will be sufficient reason for denial of benefits under the Florida Workers' Compensation Act, and will be the basis for termination.

Date: Employee Signature:

Client #: Company Name: Witnessed By:

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	- -		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States *(See instructions)*
- ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ____________
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ____________. Some aliens may write "N/A" in this field. *(See instructions)*

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: ____________

OR

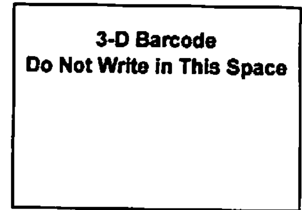
2. Form I-94 Admission Number: ____________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________

Country of Issuance: ____________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*



Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

Employer Completes Next Page

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				3-D Barcode Do Not Write in This Space
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: ______________ *(See instructions for exemptions.)*

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

L&D Ceilings, Inc.

Employee Authorization To Mail Payroll Checks

Employee ______________________________

Employee ID ___________

Please mail my payroll check each week to the following address:

____

____

I _______________ authorize L & D Ceilings to mail my payroll checks as noted above.

____________________________________ ____________________
Date

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Employee Name:______________________________

Social Security #:______________________________

I hereby authorize Direct Deposit to my Checking and/or Savings account(s) in the Financial Institution named below.

Please allow two pay periods for a Direct Deposit initiation, termination or change.

Institution Name:______________________________
Routing Number:______________________________
Account Number:
Checking #_______________ Amt. Each Pay $__________
Savings #_______________ Amt. Each Pay $__________

Institution Name:______________________________
Routing Number:______________________________
Account Number:
Checking #_______________ Amt. Each Pay $__________
Savings #_______________ Amt. Each Pay $__________

This authorization is to remain in effect until written notification from me, termination or a change received from L & D Ceilings.

______________________ ______________________
SIGNATURE **DATE**