# WDR MECHANICAL CONTRACTORS, INC.
# EMPLOYMENT APPLICATION

PERSONAL INFORMATION DATE

| | | |
|---|---|---|
| NAME: | | SOCIAL SECURITY NO. |
| ADDRESS: | | PHONE: |
| ARE YOU A CITIZEN OF THE UNITED STATES? | ARE YOU 18 YEARS OR OLDER? | DRIVERS LICENSE NO: |

EMPLOYMENT DESIRED:

| | | |
|---|---|---|
| POSITION | DATE YOU CAN START: | SALARY DESIRED: |
| ARE YOU NOW EMPLOYED? | MAY WE INQUIRE AT PRESENT EMPLOYER? | EVER WORKED HERE BEFORE? WHEN? |
| EVER APPLIED TO THIS COMPANY BEFORE? | REFERRED BY: | |

EDUCATION AND GENERAL INFORMATION

| | | |
|---|---|---|
| LAST GRADE COMPLETED: | | WHERE: |
| TRADE OR OTHER SCHOOL: | | WHERE: |
| SPECIAL SKILLS: | | |
| US MILITARY SERVICE: | | |

PREVIOUS EMPLOYMENT (LAST THREE JOBS)

| DATES | EMPLOYER AND ADDRESS | REASON FOR LEAVING |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

REFERENCES

| NAME | ADDRESS | TELEPHONE |
|---|---|---|
| 1. | | |
| 2. | | |

In case of emergency notify:_____PHONE_____

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you all information concerning my previous employment and any pertinent information they may have and release all parties from all liability for any damage that my result from furnishing same to you. I understand and agree that if hired, my employment is for no definite period and may, regardless of the payment of my wages and salary, be terminated at any time without prior notice and without cause.

DATE _____ SIGNATURE _____

## WDR MECHANICAL CONTRACTORS, INC.
### DRUG TESTING CONSENT AND RELEASE FORM

1. I hereby consent to submit to urinalysis and/or other tests as shall be determined thereof by the company as a condition of employment and for the purpose of determining the drug content.

2. I agree that a H.H.S. and Florida certified lab may collect these specimens for these tests and may use them or forward them to a testing laboratory designated by the company for analysis.

3. I further agree to have these results reviewed by a Medical Review Officer.

4. I hereby release to the Company the results of the tests to which I have consented. I further authorize the Company to discuss the results with medical personnel collecting the specimen, the testing facility, its directors, officers, agents and employees responsible for administering the aforementioned tests or evaluating the results thereof and any of them herein and to use the test results as a defense to any legal action to which I am party.

5. I further release any testing facility or any physicians who have tested me from any liability arising from a release to any and all results, written reports, medical records and data concerning my tests to the appropriate Company officials or government agencies.

6. I further agree that a reproduced copy of this consent and release form shall have the same force and effect as the original.

7. I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not be coerced into signing this document by anyone.

Printed Name_____ Signature_____

Date _____ Witness _____

### ACCESS TO EMPLOYEE EXPOSURE AND MEDICAL RECORDS FOR WDR MECHANICAL CONTRACTORS, INC.

EMPLOYEE NAME _____

29 CFR 1910.20, ACCESS TO EMPLOYEE EXPOSURE AND MEDICAL RECORDS, requires all new employees upon entering employment and at least annually thereafter, be informed of the following:

A. Medical records for each employee of this company is maintained in a confidential file, located at 3018 N. Davis Highway, Pensacola, Florida. Employees and their designated representative shall have access to these records, except when prohibited as described in paragraph e,2,ii,d, upon request.

B. The office manager is responsible or maintaining all exposure/medical records and will provide access to employees or their designated representative upon request.

C. Employee's rights to their exposure/medical record is outlined in the federal standard. A copy of this standard is available within the department for your review. If you would like a copy of this standard, one will be provided upon request.

Please sign and date on the line provided to indicate you have been informed on the above. This form will be retained in your medical record file.

Date _____ Signature_____

# WDR MECHANICAL CONTRACTORS, INC.
## MEDICAL INFORMATION FORM

1. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS OR DISEASE? WRITE YES OR NO TO INDICATE YOUR ANSWERS

| | YES OR NO | | YES OR NO |
|---|---|---|---|
| EPILEPSY (SEIZURES OR CONVULSIONS | | PRIOR INDUSTRIAL ACCIDENTS WITH THIS COMPANY OR AFFILIATED COMPANY | |
| DIABETES (EXCESSIVE SUGAR IN BLOOD) | | ANY PERMANENT PHYSICAL CONDITIONS WHICH CONSTITUTES A 20% IMPAIRMENT OF A MEMBER OF YOUR BODY OR OF THE BODY AS A WHOLE | |
| CARDIAC DISEASE | | RHEUMATIC FEVER | |
| AMPUTATION OF FEET, LEG, ARM OR HAND | | HIGH BLOOD PRESSURE | |
| TOTAL LOSS OF SIGHT OF ONE OR BOTH EYES | | VARICOSE VEINS OR LEG ULCER | |
| RESIDUAL DISABILITY FROM POLIO | | CHEST PAIN | |
| PALSY | | TUBERCULOSIS | |
| MULTIPLE SCLEROSIS | | ALLERGIES | |
| PARKINSON'S DISEASE | | HAY FEVER | |
| DELAYED BLOOD CLOTTING | | SKIN TROUBLE | |
| LOW BLOOD SUGAR | | REACTION TO SERUM OR DRUGS | |
| MUSCULAR DYSTROPHY | | KIDNEY OR BLADDER TROUBLE | |
| INFLAMMATION OF A VEIN | | ULCERS | |
| SLIPPED DISK | | HEAD INJURY | |
| SURGICAL REMOVAL OF DISK | | CANCER | |
| DEAFNESS | | DIZZINESS OR FAINTING SPELLS | |
| MENTAL RETARDATION | | ARTHRITIS | |
| KNEE SURGERY | | KNEE INJURY | |
| REMOVAL OF KNEE CAP | | BACKACHE | |
| TORN LIGAMENTS | | SHOULDER INJURY | |
| FUSION OF A MAJOR WEIGHT BEARING JOINT | | ALCOHOLISM | |
| BACK INJURIES RESULTING IN DISABILITY OF MORE THAN 120 DAYS | | DRUG ADDICTION | |
| SEVERE HEADACHES | | CHRONIC COUGH | |
| SHORTNESS OF BREATH | | NERVOUS BREAKDOWN | |
| MENTAL ILLNESS, PSYCHIATRIC TREATMENT OR PROFESSIONAL COUNSELING | | | |

2. Please list any condition, injury or disease for which you have been treated in the last three years.

3. Have you ever been hospitalized? If so, what condition? If not, state "none"

4. Have you ever been treated by a psychiatrist or psychologist? If so, for what condition? If no such treatment has been received, state"none".

## WDR MECHANICAL CONTRACTORS, INC.
### MEDICAL INFORMATION FORM (continued)

5. Have you ever been treated for any mental condition? If no such treatment has been received, state "none".

_____

6. Is there any health related reason you may not be able to perform the job for which you are applying? If yes, explain.

_____

7. Have you had a major illness in the last five years? If none, state "none".

_____

8. How many days were you absent from work last year due to illness?

_____

9. Do you have any physical defects which preclude you from performing certain kinds of work? If so, describe specific limitations. _____

10. Do you have any disabilities or impairments which may affect your performance in the position for which you are applying?

_____

11. Are you taking any prescribed drugs? If yes, state the medication and the reason for taking. If no, state "none".

_____

12. Have you ever been treated for drug addiction or alcoholism? If yes, identify the medical care provider and dates.

_____

13. Have you ever received benefits or settlement from workers' compensation insurance? If yes, give details

_____

I declare that the facts reported herein are true to the best of my knowledge and that any false or misleading statements or information I make could result in administrative action up to and including termination and/or refusal of employment. In addition, I also understand that after employment, should I aggravate a pre-existing condition for which I have not supplied truthful information, I may not be eligible to receive Workers' Compensation benefits.

Date _____ Signature _____

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY _____ DATE _____

REMARKS _____

HIRED _____ SALARY _____ DATE TO START WORK_____