

RELIABLE PRODUCTION SERVICE, INC. EMPLOYMENT APPLICATION

DATE: _____

TO APPLICANT: You must personally complete the application for It to be considered. Applications are considered effective for only (60) days. Thereafter, you must personally renew the application to be considered for employment.

NAME IN FULL (First, Middle, Last)		SOCIAL SECURITY NUMBER		Date of Birth	
PRESENT ADDRESS		CITY	STATE	ZIP	PHONE NUMBER
PERMANENT HOME ADDRESS		CITY	STATE	ZIP	SPOUSE'S NAME (if any)
IN CASE OF EMERGENCY NOTIFY:		CITY	STATE	ZIP	PHONE NUMBER
What type of Drivers License do you have?	License Number	Class	Exp Date	Restrictions	Gender
<input type="checkbox"/> Operator <input type="checkbox"/> Commercial Operator					M F

POSITION APPLIED FOR: _____ If job moves from present location, will you accept employment on new location? Yes No

EDUCATION: Grade School _____ High School _____ College _____ Commercial _____ Other _____

ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THE U.S.A.? Yes No

IMPORTANT! Give name and address of last three employers, including Names of Supervisors

	NAME OF EMPLOYER AND SUPERVISOR	ADDRESS	TYPE OF WORK DONE	DATES EMPLOYED		REASON FOR LEAVING
				FROM	TO	
(1)						
(2)						
(3)						

Have You Had A Physical Examination In The Past 5 Years? Yes No Would You Be Willing To Take A Physical Examination If Required? Yes No

To Your Knowledge Do You Have Or Have You Ever Had Any Of The Following Ailments? Check Yes or No.

Yes No <input type="checkbox"/> <input type="checkbox"/> Ruptured <input type="checkbox"/> <input type="checkbox"/> Defective Sight <input type="checkbox"/> <input type="checkbox"/> Loss of any organ of the body <input type="checkbox"/> <input type="checkbox"/> Dizziness	Yes No <input type="checkbox"/> <input type="checkbox"/> Defective Hearing <input type="checkbox"/> <input type="checkbox"/> Back Trouble <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Epilepsy	Yes No <input type="checkbox"/> <input type="checkbox"/> Rheumatism or Arthritis <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> Silicosis or Tuberculosis
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Do you have any physical or mental condition(s) other than those identified above which would interfere with or hinder the performance of the job for which you wish to be considered? If so, please explain: _____

Have you ever had an on the job injury? Yes No If answer is yes to preceding question, complete below:

Approximate Date of Injury	Employer at Time of Injury	Nature of Injury	Were you disabled	Approximate Length of Time You Were Off Work	Was a Claim for Benefits Made ?
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> yes <input type="checkbox"/> No		<input type="checkbox"/> yes <input type="checkbox"/> No

Will you abide by the safety rules of this company? Yes No If injured, will you accept the medical facilities recommended by your employer Yes No

Have your ever been convicted of a criminal offense (do not include parking tickets)? Yes No Conviction Is not an automatic bar to employment

If Yes	DATE	NATURE OF CONVICTION	WHERE	DISPOSITION OF OFFENSE

DO NOT WRITE BELOW THIS LINE

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW

I hereby declare that I am not disabled in any way which would prevent me from steadily performing all the work applied for in this application. I further declare that the answers to the questions on all attached forms are correct and that any misstatement of fact or omission should be cause for dismissal or rejection. I authorize the company to contact any of my previous employers as well as any reference source in order to verify the facts and information I have furnished regarding my qualifications and character. I hereby authorize any person(s) having knowledge thereof to provide such information to the company, and I hereby release from liability and agree to hold harmless any person that furnishes such information in good faith. I agree that I will submit to a physical, polygraph, urinalysis, and/or blood or other examination requested by the company at any time prior to or subsequent to my employment. I authorize the company to supply my employment record in whole or in part and in confidence to any employer, Insurance agency, or other party with a legal and proper interest, and I hereby release the company from any liability and agree to hold harmless any employee of the company who furnishes such information. I further understand that my employment is for no fixed time and may be discontinued with or without cause or notice by myself or the company. I understand that no employee, officer, or agent of the company may bind it by oral or printed statements, including handbooks, benefit books, or bulletins, contrary to the above.

Under the provisions of the FAIR CREDIT REPORTING ACT, 15 U.S.C. Sec 1681, at seq. notice is hereby given that a consumer report or Investigative consumer report may be made which may include information to your credit (worthiness character, general reputation, personal characteristics, and mode of living, which will be used for employment purposes. An Investigation into your workers' compensation or industrial accident background may also be conducted.

You are further advised under said Act that any person who procures or causes to be prepared an investigative consumer report on any consumer shall, upon written request made by the consumer within a reasonable period of time after the receipt by him/her of the disclosure required by subsection 1681 (d) shall make a complete and accurate disclosure of the nature and scope of the investigation requested. This disclosure shall be made in writing, mailed or otherwise delivered not later than five days after the date on which the request for such disclosure was received from the consumer or such report was first requested, whichever is the latter.

You are further advised that if you are denied employment, either wholly or partly, because of information contained in a consumer report as that term is defined in the FAIR CREDIT REPORTING ACT, that a disclosure will be made to you of the name and address of the consumer reporting agency making such report.

I HAVE CAREFULLY READ THE INFORMATION ON THIS FORM, REALIZE I HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT IT, AND UNDERSTAND WHAT IT MEANS.

SIGNATURE OF APPLICANT

DATE

EQUAL OPPORTUNITY EMPLOYER M/F/H

CONSENT FORM
"EMPLOYER'S RIGHT OF REIMBURSEMENT FROM AN EMPLOYEE"

House Bill No. 1287

Notwithstanding any other provision of law, an employer shall have a right of reimbursement from an employee or an applicant who becomes an employee provided the employee is compensated at a rate equivalent to not less than one dollar above the existing federal minimum wage and is not a part-time or seasonal employee as defined in R.S.23:1021, for the cost of such employee's or an applicant's pre-employment medical examination or drug test if the employees terminates the employment relationship sooner than ninety (90) working days after his first day of work or never reports to work, unless such termination is attributable to a substantial change made to the employment by the employer as applied in Louisiana Employment Security Law.

I, _____ agree that If I am hired by Reliable Production Services, Incorporated and I voluntarily leave employment within ninety (90) days that Reliable Production Services, Incorporated has the right to reimbursement for the cost of my pre-employment doctor's physical, physical capabilities test and drug/alcohol screening for a total approximate cost of

Employee Date

MOTOR VEHICLE CHECK

Full Name (as shown on drivers license)- _____

Date of Birth - _____

Complete Drivers License Number - _____

State of Issue of Drivers License - _____

Release of Prospective Driver:

I understand that the above information will be used to obtain a copy of my motor vehicle record (MVR) and this information may be used for insurance and employment purposes.

Signature of Driver - _____

Printed Name of Driver - _____

Date Signed - _____