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| **PHENIX OF IDAHO, INC.** | **Application for Employment** |

**PERSONAL**

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| **Last Name First Middle** | **Date:** |
| **Street Address: Home Phone:** | |
| **City, State Zip Business Phone:** | |

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| **Have you ever applied for employment with us? ❒ Yes ❒ No**  **If yes, Month and Year:** | **Social Security #:**  **- -** | | |
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| **Position Desired:** | | | |
| **Date Available to Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your desired salary?** | | **$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Are you currently employed?** | | | **❒ Yes ❒ No** |
| **Are you eligible for employment in the United States?** | | | **❒ Yes ❒ No** |
| **Are you available to work: ❒ Full-time ❒ Part-time ❒ Temporary** | | | |
| **Are you currently on “lay-off” status and subject to recall?** | | | **❒ Yes ❒ No** |
| **Can you travel if a job requires it?** | | | **❒ Yes ❒ No** |
| **Special training or skills (languages, machine operations, etc.)** | | | **❒ Yes ❒ No** |
| **Please Explain:** | | | |
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**EDUCATION**

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| **SCHOOL** | **NAME AND LOCATION OF SCHOOL** | **From** | **To** |  | **DIPLOMA/**  **DEGREE** |
| **School** |  |  |  |  |  |
| **Undergraduate College** |  |  |  |  |  |
| **Graduates/**  **Professionals** |  |  |  |  |  |
| **Other (Specify)** |  |  |  |  |  |

**WORK EXPERIENCE**

**Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude information which indicates race, color, religion, gender, national origin, disabilities or other protected status.**

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| **Employer:** |  | **Dates Employed** | | **Work Performed** |
| **Address:** |  | **From** | **To** |  |
| **Phone #:** |  |  |  |  |
| **Starting/Present**  **Job Title:** |  |  |  |  |
| **Supervisor:** |  | **Wage Rate:** | |  |
| **Reason for Leaving:** | | | | |

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| **Employer:** |  | **Dates Employed** | | **Work Performed** |
| **Address:** |  | **From** | **To** |  |
| **Phone #:** |  |  |  |  |
| **Starting/Present**  **Job Title:** |  |  |  |  |
| **Supervisor:** |  | **Wage Rate:** | |  |
| **Reason for Leaving:** | | | | |

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| **Employer:** |  | **Dates Employed** | | **Work Performed** |
| **Address:** |  | **From** | **To** |  |
| **Phone #:** |  |  |  |  |
| **Starting/Present**  **Job Title:** |  |  |  |  |
| **Supervisor:** |  | **Wage Rate:** | |  |
| **Reason for Leaving:** | | | | |

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| **Employer:** |  | **Dates Employed** | | **Work Performed** |
| **Address:** |  | **From** | **To** |  |
| **Phone #:** |  |  |  |  |
| **Starting/Present**  **Job Title:** |  |  |  |  |
| **Supervisor:** |  | **Wage Rate:** | |  |
| **Reason for Leaving:** | | | | |

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| **We may contact the employers listed above unless you indicate those you do not want us to contact.** |
| **DO NOT CONTACT** |
| **Employer Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**MILITARY**

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| **Did you serve in the U.S. Armed Forces?: ❒ Yes ❒ No** | |
| **If yes, in what Branch?:** |  |
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**REFERENCES EXCLUDING FORMER EMPLOYERS OR RELATIVES**

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| **NAME** | **ADDRESS & TELEPHONE NO.** | **POSITION/BUSINESS CONNECTION** | **YEARS KNOWN** |
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| **In accordance with the American Disabilities Act 942 USC 12101, Title 1, Sec. 102(d)(2)(B) and Act 942 USC 12101, Title 1, Sec. 102(d)(3)(B) will you please answer the following questions:** |
| **Are you able to perform the following functions repetitively during an entire normal eight (8) hour day without restriction or pain?** |

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| **Lift up to 80 lbs. objects?** | **❒ Yes ❒ No** | **If no, how many lbs?** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.** |
| **Bending?** | **❒ Yes ❒ No** | **Squating?** | **❒ Yes ❒ No** |
| **Twisting?** | **❒ Yes ❒ No** | **Drive long haul trucks?** | **❒ Yes ❒ No** |
| **Loading and/or unloading trucks?** | **❒ Yes ❒ No** | **Sitting?** | **❒ Yes ❒ No** |

**BEING DULY SWORN, THE UNDERSIGNED RELEASES TO PHENIX ALL RELATED MEDICAL INFORMATION AND STATES THAT ALL THE ABOVE ANSWERS ARE TRUE AND CORRECT THIS \_\_\_\_\_\_\_\_\_\_\_ DAY OF ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , 200\_\_\_\_\_\_\_\_\_\_\_ .**

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|  | **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **SIGNATURE OF JOB APPLICANT** |

**PHYSICIAN EXAMINATION (If you are hired, complete this portion.)**

In accordance with 942 USC 12101, Title 1, Sec. 102 (d) (3), every person seeking employment with PHENIX Construction must have the following doctor’s examination filled out and completed prior to starting employment.

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| **Patient Name: Name:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Address:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Position Applied: For:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Physician: Name:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Examination/Notes:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Diagnosis/Prognosis:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Based upon your examination, are there any answers to the previous questions answered by Job Applicant that would be modified based upon your examination: ❒ Yes ❒ No**

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| **If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHENIX OF IDAHO, INC.**

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| **Applicant’s Name:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Address:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Telephone:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**In accordance with the American Disabilities Act 942 USC 12101, Title 1, Sec. 102(d)(3)(B) will you please answer the following questions:**

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| **1.** | **Please list all doctors or medical care providers you have seen in the last five(5) years. If “none”, write in your own handwriting the word “none”.** |
|  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **2.** | **Please list all industrial (workman’s comp) accidents in which you have been involved in the last five (5) years. If “none”, write in your own handwriting the word “none”.** |
|  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**BEING DULY SWORN, THE UNDERSIGNED RELEASES TO PHENIX ALL RELATED MEDICAL INFORMATION AND STATES THAT ALL THE ABOVE ANSWERS ARE TRUE AND CORRECT THIS DAY \_\_\_\_\_\_ OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 200\_\_\_\_.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF JOB APPLICANT**

**INFORMATION AND MEDICAL AUTHORIZATION**

To Whom This May Concern:

You are hereby authorized and directed to permit the examination, inspection, copying or reproduction in any manner, whether mechanical, photographic or otherwise, by the PHENIX OF IDAHO, INC., P.O. Box 1626, Idaho Falls, Idaho 83402-1768, or such associates, agents, or representatives as they may authorize, of all or any portion of any information or medical records which you may have of any nature whatsoever concerning said individual. This authorization shall consist of my voluntary release of all of my past medical records to said PHENIX OF IDAHO, INC.

This authorization is given voluntarily by me in accordance with The American Disabilities Act 942 USC 12101, Title 1, separate forms and maintained in separate medical files and *shall continue in effect until revoked in writing by me.*

A photocopy of this information authorization shall be considered as effective and valid as the original.

DATED this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , 200\_\_\_\_.

|  |  |
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|  | Patient/Claimant /Employer Authorization: |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Social Security Number |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Birth Date |

|  |
| --- |
| STATE OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  ) ss.  County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |

On this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 200\_\_\_, before me, a Notary Public in and for the State of Idaho, personally appeared \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, known to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal, the day and year in this certificate first above written.

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|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Notary Public for Idaho |

(SEAL)