MIDSOUTH MECHANICAL, INC.

In compliance with Federal and State equal employment opportunity laws, qualified applicants are considered for all positions without regard to race, color, religion, national origin, age, martial status, or non job related disability. We are an equal opportunity employer and all applicants are encouraged to apply for any and all positions within the company.

Application for Employment

WE DRUG TEST ALL APPLICANTS ONCE A CONDITIONAL OFFER OF EMPLOYMENT WITH THIS COMPANY HAS BEEN ACCEPTED. WE ALSO VERIFY YOUR PAST MEDICAL AND WORKERS' COMPENSATION CLAIMS HISTORY ONCE AN OFFER OF CONDITIONAL EMPLOYMENT HAS BEEN ACCEPTED.

(Answer all questions—please print in ink)

Position for which you are applying: Today's Date:_____

_____

Name:_____ Social Security No:_____
Last First Middle

__ Drivers License No:_____

Where have you lived the last three (3) years? State Issued:_____

Current Address: _____
Street City State Zip

_____ How long at this address?_____
Telephone

Previous Address: _____
Street City State Zip
How long did you live there?_____

Previous Address: _____
Street City State Zip
How long did you live there?_____

Previous Address: _____
Street City State Zip
How long did you live there?_____

Do you have the legal right to work in the United States?_____

Date of Birth:_____ Emergency Contact & Phone: _____

Have you ever worked for us before?_____ Where?_____ When?_____

Reason you left our employment?_____

Are you employed now?_____ If not, how long has it been since you were employed?_____

How were you referred to us?_____

Is there any reason you might be unable to perform the functions of the job for which you have applied? If the answer is "YES" please explain:

_____
_____
_____

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Work History

List former employers in reverse order starting with the most recent. Add another sheet if necessary.

Employer Name:______________________________ Date From________ To________

Address:______________________________ Position:______________

City:______________ State:__________ Zip:__________ Salary:______________

Contact Person:______________________________ Phone:______________

Reason for Leaving:______________________________

Employer Name:______________________________ Date From________ To________

Address:______________________________ Position:______________

City:______________ State:__________ Zip:__________ Salary:______________

Contact Person:______________________________ Phone:______________

Reason for Leaving:______________________________

Employer Name:______________________________ Date From________ To________

Address:______________________________ Position:______________

City:______________ State:__________ Zip:__________ Salary:______________

Contact Person:______________________________ Phone:______________

Reason for Leaving:______________________________

Employer Name:______________________________ Date From________ To________

Address:______________________________ Position:______________

City:______________ State:__________ Zip:__________ Salary:______________

Contact Person:______________________________ Phone:______________

Reason for Leaving:______________________________

Employer Name:______________________________ Date From________ To________

Address:______________________________ Position:______________

City:______________ State:__________ Zip:__________ Salary:______________

Contact Person:______________________________ Phone:______________

Reason for Leaving:______________________________

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List all accidents you have been involved in, in the past 3 years. Attach an additional sheet if necessary.

Most Recent Accident	Nature of Accident/Work Comp	Injuries
Next		
Next		
Next		
Next		

Driving Experience

Have you ever been denied a license to operate a motor vehicle? Yes_____ No_____
Have you ever had a driver's license suspended or revoked? Yes_____ No_____

Do you have the following experience?

Class of Equipment	Type of Equipment	From	To
Cranes			
Electrical			
Loaders/Forklift			
Other			

Do you have any applicable training (OSHA 10, OSHA30, etc)

Type of Training Issue Date Expiration Date

List any special technical skills you may possess?

Show any other experience that may help in your work for our company.

Education

Circle the highest Grade Completed: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4

Last School Attended:_____
School Name City State

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To be read and signed by the Applicant

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge. I authorize you to make such investigations and inquiries of my personal, employment, financial, or medical history and other related matters as may be necessary in arriving at an employment decision. Inquiries regarding my medical history will be made only if and after a conditional offer of employment has been extended.

I hereby release former employers, schools, health care providers, and other persons from all liability in responding to inquiries and releasing information in connection with my application.

In the event of employment, I understand that false or misleading information given in my application or during any interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Company.

Date

Applicant's Signature

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Have you had other injuries or illnesses not on the job (home, auto, sports, hunting, etc.) that have resulted in hospitalization, surgery, or lost work time? Yes_____ No _____

If "yes" please describe:	1	2	3
Date of Injury/Illness			
Body part affected			
Cause			
Days in Hospital			
Days lost work time			
Have you fully recovered?			

Are you taking any prescription medication on a long term basis? (More than 30 days)

Yes_____ No _____

If your answer was yes, please describe:_____

Affirmation and Authorization:

I hereby affirm that the information on this form is true and correct, and that there are no omissions. I authorize any medical facility, physician, law enforcement agency, administrator, state agency, institution, information service bureau, insurance company or employer contacted by the Company or an authorized agent of the company to furnish or verify workers' compensation information and medical records.

I further acknowledge that a fax or photographic copy shall be as valid as the original.

Date: _____ Your Signature: _____

Date: _____ Company Representative:_____