



Please fill out **COMPLETELY** and **ACCURATELY**. If not filled out completely and accurately you **WILL NOT** BE considered for employment. Background checks will be ran on all applicants being considered. If any **FALSIFICATIONS** are found after employment begins, you will be terminated.

Position applied for PLEASE PRINT _____ Date Available / Date Applied _____

Last Name _____ First _____ Middle _____

Street Address _____ Social Security #: _____

City _____ State _____ Zip code _____ Phone Number _____

Do you have _____ No Do you have _____ No State Licensed License Number Class
Reliable a valid driver's
Transportation? _____ Yes license? _____ Yes

PREVIOUS EMPLOYMENT RECORD

Have you ever worked for HWD or Akerman Construction _____ If No how did you hear about us?
_____ Yes _____ No
If yes Which Company? _____ Year _____

NAME AND ADDRESS OF LAST 3 EMPLOYERS Begin with most recent

Name _____ Phone _____ Position Held _____ Date Employment Began _____
Address _____ Rig Size _____ Date Employment Ended _____
Reason For Leaving _____ Beginning pay rate _____ Ending pay rate _____

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Reason For Leaving _____ Beginning pay rate _____ Ending pay rate _____

EDUCATION—HIGHEST GRADE COMPLETED

High School Grade Completed _____ College / University Years Completed _____

CERTIFICATES—PLEASE ATTACH COPIES

Occupational Health Confidential Pre- Placement Health Assessment

PERSONAL INFORMATION

Employee Full Name _____ Birthday _____ Age _____ Sex _____ Marital Status _____

Address _____ Home Phone Number _____

FAMILY HEALTH HISTORY

Relation	Age	Health (If Deceased—age and cause)	Check if any near Relative Has/Had
Father			___ Asthma/Allergies ___ Cancer
Mother			___ Diabetes ___ Heart Disease
Sisters			___ Neurological ___ Strokes
Brothers			Disorders or Epilepsy
Children			___ Blood Disorders ___ Kidney Disease
			___ Mental Disorders ___ High Blood Pressure

PERSONAL HEALTH HISTORY

Are you Currently Under a Doctors Care? ___ Yes ___ No If yes Explain _____

Are you Currently Taking Prescription Drugs ? ___ Yes ___ No If yes Explain _____

Have you ever had or do you now have any problems related to:

	Yes	No		Yes	No	Yes	No
Eye of Vision Defects	_____	_____	Lungs, Pneumonia	_____	_____	Back Pain	_____
Ear of Hearing Defects	_____	_____	Rheumatic Fever	_____	_____	Varicose Veins, Hemorrhoids	_____
Frequent Headaches	_____	_____	Shortness of Breath	_____	_____	Anemia, Blood Disorder	_____
Dizzy Spells	_____	_____	Swelling of Ankles	_____	_____	Diabetes	_____
Epilepsy, Convulsions	_____	_____	Heart Trouble	_____	_____	Skin Trouble	_____
Fainting, Paralysis	_____	_____	High Blood Pressure	_____	_____	Loss of Weight, Appetite	_____
Nose, Sinus	_____	_____	Bowel, Stomach	_____	_____	Frequent Indigestion	_____
Throat, Thyroid	_____	_____	Liver, Gallbladder	_____	_____	Kidney, Bladder	_____
Chest Pain	_____	_____	Hernia	_____	_____	Allergies	_____
Arthritis, Rheumatism	_____	_____	Fractures, Dislocations	_____	_____	Operations, Hospitalization	_____
Tobacco Consumed	_____	_____	Amount per Week _____	_____	_____	Carpal Tunnel Syndrome	_____
Alcohol Consumed	_____	_____	Amount per Week _____	_____	_____	Other Illness, Injury,	_____
						Health Compliant	_____

Please complete Next Page

