APPLICATION FOR EMPLOYMENT

(PRE-EMPLOYMENT QUESTIONNAIRE) (AN EQUAL OPPORTUNITY EMPLOYER)

PERSONAL INFORMATION

DATE

NAME _____ SOCIAL SECURITY NUMBER _____

LAST FIRST MIDDLE

PRESENT ADDRESS _____

STREET CITY STATE ZIP

PERMANENT ADDRESS _____

STREET CITY STATE ZIP

PHONE NO. _____ ARE YOU 18 YEARS OR OLDER? Yes ☐ No ☐

EMAIL _____

ARE YOU PREVENTED FROM LAWFULLY BECOMING EMPLOYED IN THIS COUNTRY BECAUSE OF VISA OR IMMIGRATION STATUS? Yes ☐ _____ No ☐ _____

EMPLOYMENT DESIRED

POSITION _____ DATE YOU CAN START _____ SALARY DESIRED _____

ARE YOU EMPLOYED NOW? _____ IF SO MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? _____

EVER APPLIED TO THIS COMPANY BEFORE? _____ WHERE? _____ WHEN? _____

REFERRED BY _____

EDUCATION	NAME AND LOCATION OF SCHOOL	*NO OF YEARS ATTENDED	*DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

GENERAL

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK _____

SPECIAL SKILLS _____

ACTIVITIES: (CIVIC, ATHLETIC, ETC.)

EXCLUDE ORGANIZATIONS, THE NAME OF WHICH INDICATES THE RACE, CREED, SEX, AGE, MARITAL STATUS, COLOR OR NATION OF ORIGIN OF ITS MEMBERS.

U.S. MILITARY OR NAVAL SERVICE _____ RANK _____ PRESENT MEMBERSHIP IN NATIONAL GUARD OR RESERVES _____

LAST FIRST MIDDLE

*This form has been revised to comply with the provisions of the Americans with Disabilities Act and the final regulations and interpretive guidance promulgated by the EEOC on July 26, 1991.

(CONTINUED ON OTHER SIDE)

FORMER EMPLOYERS (LIST BELOW LAST THREE EMPLOYERS, STARTING WITH LAST ONE FIRST).

DATE MONTH AND YEAR	NAME AND PHONE OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				
FROM				
TO				
FROM				
TO				

WHICH OF THESE JOBS DID YOU LIKE BEST?

WHAT DID YOU LIKE MOST ABOUT THIS JOB?

REFERENCES: GIVE THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	PHONE	BUSINESS	YEARS ACQUAINTED
1			
2			
3			

THE FOLLOWING STATEMENT APPLIES IN: MARYLAND & MASSACHUSETTS. (Fill in name of state)
IT IS UNLAWFUL IN THE STATE OF _____ TO REQUIRE OR ADMINISTER A LIE DETECTOR TEST AS A CONDITION OF EMPLOYMENT OR CONTINUED EMPLOYMENT. AN EMPLOYER WHO VIOLATES THIS LAW SHALL BE SUBJECT TO CRIMINAL PENALTIES AND CIVIL LIABILITY.

_____
Signature of Applicant

IN CASE OF EMERGENCY NOTIFY _____
NAME ADDRESS PHONE NO.

"I CERTIFY THAT ALL THE INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE AND COMPLETE, AND I UNDERSTAND THAT IF ANY FALSE INFORMATION, OMISSIONS, OR MISREPRESENTATIONS ARE DISCOVERED, MY APPLICATION MAY BE REJECTED AND, IF I AM EMPLOYED, MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME.
IN CONSIDERATION OF MY EMPLOYMENT, I AGREE TO CONFORM TO THE COMPANY'S RULES AND REGULATIONS, AND I AGREE THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME, AT EITHER MY OR THE COMPANY'S OPTION. I ALSO UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS OF MY EMPLOYMENT MAY BE CHANGED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME BY THE COMPANY. I UNDERSTAND THAT NO COMPANY REPRESENTATIVE, OTHER THAN IT'S PRESIDENT, AND THEN ONLY WHEN IN WRITING AND SIGNED BY THE PRESIDENT, HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIC PERIOD OF TIME, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING."

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY _____ DATE _____

REMARKS: _____

NEATNESS _____ ABILITY _____

HIRED: ☐ Yes ☐ No POSITION _____ DEPT. _____

SALARY/WAGE _____ DATE REPORTING TO WORK _____

APPROVED: 1. _____ 2. _____ 3. _____
EMPLOYMENT MANAGER DEPT. HEAD GENERAL MANAGER

Mail or personally deliver this form to:
TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite 100, MS-92B
Austin, TX 78744

THIS FORM MUST BE FILLED OUT COMPLETELY AND MUST BE SIGNED AND DATED BEFORE A NOTARY.

PROSPECTIVE EMPLOYMENT AUTHORIZATION AND CERTIFICATION

Please carefully read the instructions on the reverse side before submitting this form. Incorrect/incomplete forms will be returned without action

SECTION I: TO BE COMPLETED BY JOB APPLICANT

1. Name of Job Applicant (Print or type)	3. Social Security Number
2. Complete Address of Job Applicant (Print or type)	4. Date Job Application Submitted

I understand that the Texas Workers' Compensation Act provides for the release of certain prior work related injury information to prospective Texas employers who carry workers' compensation insurance if the employer obtains my written authorization before making a request for that information. I also understand that if this employer is covered by the Americans With Disabilities Act, my prior work related injury claim information may be released only if the indicated employer has properly completed and certified the information on this form. Prospective employers filing valid requests will be provided with a report on prior work related injury claims only if an applicant has made two or more general injury claims in the preceding five years. I hereby authorize release of information permitted by law on my work related injuries to the prospective employer named below.

Job Applicant's Signature _____ Date _____

SWORN AND SUBSCRIBED TO BEFORE ME BY THE SAID _____ (Print Job Applicant's Name)

ON THIS _____ DAY OF _____, YEAR _____.

_____ _____
Signature of Notary Public Print Name of Notary Public

(Seal or Stamp)

My Commission expires: _____

SECTION II: TO BE COMPLETED BY PROSPECTIVE TEXAS EMPLOYER

1. Name of Employer (Print or type)	3. Employer's Federal Tax I.D. #	4. Date Job Application Received
2. Address and Phone Number of Employer (Print or type) Phone Number ( )		5. Prepaid Account Number

I am a prospective Texas employer who has workers' compensation insurance. I am entitled to receive prior injury information concerning this job applicant under the Texas Workers' Compensation Act, Texas Labor Code, Section 402.087. I am not prohibited from receiving this information under the Americans With Disabilities Act of 1990, 42 U.S.C. §12101 *et. seq.* because:

(Employer Must Check One):

☐ I am a Texas employer who is not covered by the Americans With Disabilities Act of 1990. (The Americans With Disabilities Act of 1990 defines "employer" as: "a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding year and any agent of such person").

☐ I am a Texas employer who is covered by the Americans With Disabilities Act of 1990, who is requesting this information prior to hiring the above-named job applicant, but after having made a conditional offer of employment to the above-named applicant. I am requesting this information regarding all post-offer prospective job applicants in this job category, regardless of disability. Information concerning the Americans With Disabilities Act may be obtained by calling 1 (800) 949-4232; TDD 1 (713) 520-5136 or the Texas Commission on Human Rights, (512) 437-3450.

A $2.00 fee is required of the prospective employer per request. Your remittance must be attached. The DWC FORM-156 will be returned without action if payment is not enclosed. Fees are subject to change. Make checks payable to DWC.

I certify that I am an authorized representative of this employer and the statements in Section II of this document are true, complete and correct to the best of my knowledge and belief.

Employer/Representative's Signature _____ Date _____

SWORN AND SUBSCRIBED TO BEFORE ME BY THE SAID _____ (Print Employer/Rep. Name)

ON THIS _____ DAY OF _____, YEAR _____.

_____ _____
Signature of Notary Public Print Name of Notary Public

(Seal or Stamp)

My Commission Expires: _____

Quarles Lumber Consumer Report Disclosure and Authorization Form

John E Quarles Co., dba Quarles Lumber may, with your consent, obtain a consumer report, as defined by the Fair Credit Reporting Act (FCRA), from Imperative Information Group, Inc., a consumer reporting agency, related to your prospective, continued, or future employment. Such report may include, as allowed by law, information regarding previous or current military service, employment, education, criminal, driving history, credit or other matters that may be relevant to the position sought or held.

This may include procurement of an investigative consumer report (defined as a report that includes information as to your character, general reputation, personal characteristics, or mode of living obtained through personal interviews). You may request that the nature and scope of any investigative consumer report be disclosed to you.

Identity Information– This information will be used only in preparing a consumer report.

First Name:

Middle Name:

Last Name:

Other Names Used:
(maiden names or aliases)

Email Address:

Social Security Number: - -

Date of Birth: Month: Day: Year:

Current Home Address:

City: State: ZIP:

Drivers License State: Number:

Please list each city/county and state in which you have lived, worked, or attended school during the last ten years. Use a second form if necessary to provide full disclosure.

City: OR County: State:

City: OR County: State:

City: OR County: State:

By signing below, I:

- Authorize John E Quarles Co., dba Quarles Lumber or any of its affiliated or successor companies to obtain the consumer reports described above at any time in connection with my prospective or continued employment,
- Acknowledge receipt of the summary of my rights under the FCRA, and
- Request and authorize all individuals, agencies, and businesses to release information regarding my previous or current military service, employment, education, criminal or civil litigation, conduct, experience, or other matters to Imperative Information Group, Inc., including information which may be deemed negative, in order to complete these reports, to the extent allowable under law.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: _____ _____
Date Signature

CDL APPLICANTS ONLY

DRUG AND ALCOHOL TESTING AND SAFETY PERFORMANCE HISTORY INQUIRY

Applicant full name:_____ SSN:_____

Application date: _____ Date of birth: _____

SECTION 1 - SECTION 1 – DRUG AND ALCOHOL TESTING HISTORY

Previous Employer: _____

Street Address: _____

City, State, Zip:_____ Phone:_____

In accordance with 49 CFR §40.25(g) and §391.23(h), I hereby authorize the employer listed above to release and forward the information requested in this section concerning my alcohol and controlled substance testing records within the previous three years from the application date listed above, to Imperative Information Group, Inc. on behalf of John E Quarles Co., dba Quarles Lumber.

_____ _____

Applicant's Signature Date

Please send your response via fax to toll free 877-921-2108, email to requests@imperativeinfo.com, or mail to **Imperative Information Group, Attn: DOT Responses, 1550 West Berry Street, Fort Worth, Texas 76110.**

APPLICANT: DO NOT WRITE BELOW THIS LINE

1. In the **three year** period before the application date above, did the applicant work for the listed employer in a safety-sensitive function that required alcohol and controlled substance testing specified by 49 CFR Part 40? ☐ Yes ☐ No
2. Did this driver violate any of the prohibitions under 49 CFR part 382 subpart B or 49 CFR part 40 within the **three years** previous to the application date listed above? ☐ Yes ☐ No
3. Did this individual violate a DOT drug and alcohol regulation ***and*** fail to undertake or complete a rehabilitation program prescribed by a substance abuse professional (SAP) pursuant to 49 CFR §382.605 or 49 CFR part 40, subpart O? *If "yes", please provide available documentation.* ☐ Yes ☐ No
4. Did this individual participate in and complete a SAP's rehabilitation referral and remain in your employ ***and*** subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refuse to be tested? *If "yes", please provide available documentation.* ☐ Yes ☐ No
5. If you are a DOT-regulated employer and have employed this individual during any period during the **two years** before the application date above, please provide the following information:
   - Alcohol tests with a result of 0.04 or higher alcohol concentration.
   - Verified positive drug tests.
   - Refusals to be tested (including verified adulterated or substituted drug test results).
   - Other violations of DOT agency drug and alcohol testing regulations.
   - With respect to any violation of a DOT drug and alcohol regulation, documentation of the employee's successful completion of DOT return-to-duty requirements (including follow-up tests).
   - Any report of a drug and alcohol violation received from a previous employer.

SECTION 2 – EMPLOYMENT INFORMATION AND ACCIDENT HISTORY

Title:_____ Start date:_____ End date:_____

6. Does the applicant's identification and employment information above match the information in your files? ☐ Yes ☐ No
7. Reason for termination of employment: ☐ Resignation ☐ Lay-off/Reduction in force ☐ Involuntary termination
8. Is this individual eligible for rehire? ☐ Yes ☐ No - Reason: _____
9. Was the individual employed to operate a commercial motor vehicle (CMV) **and** involved in a CMV accident within the three years prior to the date of application above? ☐ No ☐ Yes - please provide documentation from your files.

SECTION 3 – ATTESTATION BY EMPLOYER

The foregoing information is accurate to the best of my knowledge and reflects the information in this employer's files.

_____ _____

Full name (please print) Title

_____ _____ _____ _____

Signature Date Phone Fax

Please call Imperative at 877-473-2287 with questions.

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