Employment Application

Applicant Information

Full Name: _____ **Date**: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ Desired Salary: **$** _____

Position Applied for: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when? _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma:: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Do you have special training or skills for the position you applied for? YES ☐ NO ☐ If yes please list: _____

_____

_____

_____

References

Please list two professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Previous Employment

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: **$** _____ Ending Salary: **$** _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: **$** _____ Ending Salary: **$** _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Driver's License

Do you have a current driver's license? State_____ #_____	YES ☐ NO☐	Any Restrictions? _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

Authorization for Reports and/or Driving Records to be obtained

_____
Date

I, _____, authorize the company delegated by Kelley Oilfield Services, Inc. to obtain consumer reports covered by the Federal Fair Credit Reporting Act and any comparable state laws that are applicable, as well as my driving record, covered by the federal Drivers Privacy Protection Act and comparable state laws that are applicable, to asses my Insurability and/or employability and for any other legally permissible purposes. By signing this authorization, I hereby provide my consent to the Company to procure such consumer reports and driving records about me from to time, as it deems appropriate, to evaluate my insurability and/or employability and for any other legally permissible purposes.

Sincerely,

_____
Signature of Employment Applicant

_____
Printed Name of Employment Applicant

_____ _____ _____
Driver's License Number & State | Social Secrity Number | Date of Birth

Kelley Oilfield Services, Inc.
Oilfield Construction & Maintenance

MEDICAL QUESTIONNAIRE

(EMPLOYERS NAME) _____

This questionnaire may be used to identify a worker's physical ability to perform the job he/she has been conditionally hired for and/or analyze or evaluate workers' compensation claims submitted in the future.

MEDICAL QUESTIONNAIRE (Please print)

Name _____
Address _____
Date of Birth _____
Social Security Number _____

Have you ever suffered a work related injury? ☐ Yes ☐ No
Have you ever filed for and/or received Workers' Compensation benefits? ☐ Yes ☐ No
If yes, list dates and describe when such claims were filed, and/or benefits received.

_____
_____

Have you ever suffered an illness or injury other than at work where you were off work, and/or had to limit your activities for more than one week?

☐ Yes ☐ No
If yes, list dates and describe all such injuries, and/or illnesses suffered.

_____
_____

Have you ever been in an automobile accident? ☐ Yes ☐ No
If yes, list dates of all such accidents, all injuries suffered including any physical restrictions imposed.

_____
_____
_____

List your family physician _____
Please check any of the following activities for which you have, or have had, a restriction:

Lifting	☐	Standing	☐	Squatting	☐
Carrying	☐	Walking	☐	Crawling	☐
Sitting	☐	Bending	☐	Climbing	☐

Give a brief description of any restrictions checked above. _____
_____
_____
_____

NOTICE: Under Section 52-1-28.3, NMSA 1978, of the New Mexico Workers' Compensation Act provides that the worker shall be entitled to NO future workers' compensation benefits if he or she knowingly and willfully conceals or makes a false representation about the information requested.

Please be advised that we will rely upon your answers to the above questions and that such reliance will be a substantial factor in your initial and continued employment with this company.

I hereby certify that the information listed above is true, correct and complete, to the best of my knowledge and that I understand all of the questions listed in this questionnaire. I further certify that I have read and understand the above Notice provision indicating that I will be entitled to NO future workers' compensation benefits if I knowingly and willfully conceal or make a false representation about the information requested.
(Please make sure the questionnaire is filled out completely before signing)

Employee Signature _____ Employer Signature _____

Date _____ Date _____

Kelley Oilfield Services, Inc.
Oilfield Construction & Maintenance

EJEMPLAR DE CUESTIONARIO MEDICO

(NOMBRE DEL EMPLEADOR) _____

Este cuestionario puede ser usado para identificar la capacidad y el estado físico del trabajador para desempeñar el trabajo que a el/ella se le haya asignado o para evaluar o analizar reclamos sometidos de cuando se lastiman en el trabajo.

CUESTIONARIO MÉDICO (Escriba)

Nombre _____

Dirección _____

Fecha de Nacimiento _____

Número de Seguro Social _____

¿Ha tenido algún daño/lastimadura anteriormente en el trabajo? ☐ Sí ☐ No

¿Ha recibido o reclamado beneficios de Compensación para los trabajadores? ☐ Sí ☐ No

Cuando; anote fechas y detalles: _____

_____

_____

¿Ha sufrido algún daño/lastimadura/enfermedad que no haya sido en el trabajo y que haya tenido que limitar sus actividades por más de una semana?

☐ Sí ☐ No

Cuando; anote fechas y detalles: _____

_____

_____

¿Ha tenido algún accidente automovilístico? ☐ Sí ☐ No

Cuando; anote fechas y detalles: _____

_____

_____

¿Quién es su médico/doctor de familia? _____

Marque las siguientes actividades por las que haya tenido o tenga restricciones:

Levantar	☐	Estar de pie	☐	Ponerse en cuclillas	☐
Carga	☐	Camina	☐	A gatas	☐
Sentar	☐	Doblar/encorvar	☐	Escalar	☐

Si algo esta marcado arriba de una descripción/explicación en detalle: _____

_____

_____

Sección 52-1-28.3, NMSA 1978, del Acto De Compensación de Trabajadores provee consecuencias para declaraciones o representaciones falsas escritas en este cuestionario, que pueden causar que el trabajador pierda sus beneficios de compensación de los trabajadores.

La información enumerada arriba es verdadera y correcta por mi mejor conocimiento y entendí todas las preguntas listadas arriba. Yo certifico que he leído y entendido la provisión notificada que indica que yo no voy a recibir beneficios de compensación de los trabajadores, si yo hábilmente y con conocimientos oculté y di falsa información o representación de mi condición médica. (Por favor esté seguro(a) que el formulario esté completamente lleno antes de firmarlo)

Firma del Empleado _____ Firma del Empleador _____

Fecha _____ Fecha _____