

PatRick Environmental, Inc. dba PatRick Corporation

PatRick considers applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

Who told you about the company? (Persons Name) _____

I understand that this is a seasonal job and if hired it is on a temporary basis only. Yes No

Date: _____ Telephone: _____

Name: Last: _____ First: _____ Middle: _____

Street Address _____

City _____ State _____ Zip _____

Are you 18 or older? Yes No Years of school completed _____

Do you have a driver's license? Yes No State & # _____ Expiration Date: _____

This must be filled out

First Call: Next of Kin
IN CASE OF EMERGENCY:

Name _____ Relationship _____

Address _____ Telephone # _____
CITY/STATE

Second Call:
IN CASE OF EMERGENCY:

Name _____ Relationship _____

Address _____ Telephone # _____
CITY/STATE

I hereby authorize you, PatRick Corporation to consult any previous employer. Yes No

Will you abide by all the **SAFETY RULES** of this company? Yes No

I will report any injury, which I received, on the job **IMMEDIATELY** to my supervisor. Yes

I have read PatRick Corporation's Company Policy and I understand it.

_____/s/_____
Signature **Date**

Have you ever been employed by this company? Yes No When? _____

Are you allergic to Bee stings? Yes No

If "Yes". Do you have a Bee Sting kit? Yes No

Are you allergic to any prescription drug or medicine? Yes No

If "Yes", please list what drug or medicine? _____

Are you willing to take a physical examination? Yes No

I understand that this application will be active for **ONLY 90 CALENDAR DAYS** from the date below. After 90 calendar days, this application will become inactive and if I wish to be considered for another job opening I must re-apply completing a new application form.

I hereby certify that the statements made by me in answer to the foregoing questions are true, complete, and correct to the best of my knowledge and belief. I understand that any false statements of any required information withheld from this form may provide grounds for the **IMMEDIATE** withdrawal of any offer of appointment or dismissal if an appointment has been accepted.

_____/s/_____

Signature

Date

YOUR WORK EXPERIENCE:

Wildland Fire Experience:

Have you been a Wildland firefighter?

Yes No

Do you have a copy of your certificate of training?

Yes No Certified Yes No

Who were you trained by _____

When _____

Do You Have?

First Aid / CPR Training

Yes No

Valid proof provided

Yes No

Chain Saw Experience

Yes No

Thinning

Yes No

Bucking

Yes No

Falling Certification

Yes No

Proof

Yes No

A/3

B/2

C/1

Who did you work for? _____

Can you repair a chain saw

Yes No

Boots, Condition of hire

Yes No

- (leather, lace-up type, min. of 8 high, with lug type soles)

Sleeping Bag

Yes No

Please List Prior Employment Experience.

Start with your **present or last job**. Include any job-related military service assignments and volunteer activities.

| Employer | | <u>Dates From</u> | <u>Employed To</u> | Work Performed |
|---------------------|------------|-----------------------------|---------------------|----------------|
| Address | | | | |
| City, State | | | | |
| Telephone Number(s) | | <u>Hourly Rate Starting</u> | <u>Salary Final</u> | |
| Job Title | Supervisor | | | |
| Reason for Leaving | | | | |

| Employer | | <u>Dates From</u> | <u>Employed To</u> | Work Performed |
|---------------------|------------|-----------------------------|---------------------|----------------|
| Address | | | | |
| City, State | | | | |
| Telephone Number(s) | | <u>Hourly Rate Starting</u> | <u>Salary Final</u> | |
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| Reason for Leaving | | | | |

| Employer | | <u>Dates From</u> | <u>Employed To</u> | Work Performed |
|---------------------|------------|-----------------------------|---------------------|----------------|
| Address | | | | |
| City, State | | | | |
| Telephone Number(s) | | <u>Hourly Rate Starting</u> | <u>Salary Final</u> | |
| Job Title | Supervisor | | | |
| Reason for Leaving | | | | |

PatRick Environmental, Inc
Equal Employment Opportunity Company

INFORMATION RELEASE

I, _____, do hereby give authorization to PatRick Corporation, for the purpose of releasing or obtaining the below listed information to or from: **Personnel File**

This information is to be regarded as privileged and confidential.

_____/s/
Perspective Employee Signature

Keith R. Rockson

PatRick Representative Signature

Date Signed (Valid for 1 year from date signed)

Information requested is as follows:

Purpose:

EMPLOYMENT VERIFICATION

DRIVING RECORD (AS NEEDED)

REFERENCE CHECK

CRIMINAL BACKGROUND (AS NEEDED)

IMPORTANT NOTICE TO ORGANIZATION OR INDIVIDUAL RECEIVING INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law (42 CRF Part 2, ORS 192.500, ORS 179.505).

You are prohibited from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by these laws and regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose

HEALTH SCREENING QUESTIONNAIRE (HSQ)

Assess your health needs by marking all true statements.

| |
|---|
| WCT Level |
| <input checked="" type="checkbox"/> Arduous |
| <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Light |

The purpose is to identify individuals who may be at risk in taking the Work Capacity Test (WCT) and recom program and/or medical examination prior to taking the WCT.

Employees are required to answer the following questions. The questions were designed, in consultation with occupational health physicians, to identify individuals who may be at risk when taking a WCT. The HSQ is not a medical examination. Any medical concerns you have that place you or your health at risk should be reviewed with your personal physician prior to participating in the WCT.

Check 'Yes' or 'No' in response to the following questions:

- Y N 1) During the past 12 months have you at any time (during physical activity or while resting) experienced pain, discomfort or pressure in your chest.

- Y N 2) During the past 12 months have you experienced difficulty breathing or shortness of breath, dizziness, fainting, or blackout?

- Y N 3) Do you have a blood pressure with systolic (top #) greater than 140 or diastolic (bottom #) greater than 90?

- Y N 4) Have you ever been diagnosed or treated for any heart disease, heart murmur, chest pain (angina), palpitations (irregular beat), or heart attack?

- Y N 5) Have you ever had heart surgery, angioplasty, or a pace maker, valve replacement, or heart transplant?

- Y N 6) Do you have a resting pulse greater than 100 beats per minute?

- Y N 7) Do you have any arthritis, back trouble, hip /knee/joint /pain, or any other bone or joint condition that could be aggravated or made worse by the Work Capacity Test?

- Y N 8) Do you have personal experience or doctor's advice of any other medical or physical reason that would prohibit you from taking the Work Capacity Test?

- Y N 9) Has your personal physician recommended against taking the Work Capacity Test because of asthma, diabetes, epilepsy or elevated cholesterol or a hernia?

Regardless whether you are taking the Work Capacity test at the Arduous, Moderate or Light duty level, a "Yes" answer requires a determination from your personal physician stating that you are able to participate.

I understand that if I need to be evaluated by a physician, it will be based on the fitness requirements of the position(s) for which I am qualified.

Signature: _____ /s/ Printed Name _____ Date _____

Administrator: _____ Date _____

Privacy Statement

The information obtained in the completion of this form is used to help determine whether an individual being considered for Wildland firefighting can carry out those duties in a manner that will not place the candidate unduly at risk due to inadequate physical fitness and health. Its collection and use are covered under Privacy Act System of Records OPM/Govt-10 and are consistent with the provisions of 5 USC 552a (Privacy Act of 1974).