



Weathercraft Company of Colorado Springs

roofing - waterproofing - sheet metal

Application for Employment

- THIS IS AN APPLICATION FOR EMPLOYMENT. ALL INFORMATION MUST BE COMPLETED BEFORE YOU WILL BE CONSIDERED ELIGIBLE FOR HIRE.
- YOU WILL NOT BE PAID FOR THE TIME REQUIRED TO FILL OUT THIS APPLICATION OR TO BE INTERVIEWED.
- PLEASE WRITE OR PRINT CLEARLY.
- SHOULD YOU HAVE ANY QUESTIONS ABOUT THE APPLICATION, PLEASE ASK FOR ASSISTANCE.
- VALID COLORADO DRIVER'S LICENCE OR I.D. AND SOCIAL SECURITY CARD ARE REQUIRED.

NAME: _____ SOCIAL SECURITY # _____

MAILING ADDRESS: _____
(STREET OR P.O. BOX) (CITY, STATE, ZIP CODE)

CONTACT PHONE NUMBERS _____

BIRTH DATE _____ PLACE OF BIRTH (city/state) _____

DRIVER'S LICENSE NO. _____ STATE _____ EXP. DATE _____

COLORADO ID NO. _____ STATE _____ EXP. DATE _____

➤ DO YOU HAVE PREVIOUS ROOFING EXPERIENCE? YES NO

➤ DESIRED PAY RATE _____

➤ LIST PREVIOUS EMPLOYMENT AND DATES OF EMPLOYMENT.

EMPLOYER	DATES OF EMPLOYMENT	CONTACT NAME & NUMBER

➤ CHECK THE ROOF SYSTEMS WITH WHICH YOU HAVE EXPERIENCE:

BUILT UP ROOF MODIFIED BITUMEN EPDM TPO TILE/SLATE SHINGLES

➤ DESCRIBE YOUR POSITION WITH EACH COMPANY (ROOFER, CARPENTER, LABOR).

- HOW MUCH WERE YOU PAID ON YOUR LAST JOB? \$_____ / HOUR
- WHY DID YOU LEAVE YOUR LAST ROOFING JOB? QUIT LAID OFF FIRED
- DID YOU LEAVE ON GOOD TERMS (ARE YOU ELIGIBLE FOR RE-HIRE)? YES NO
- DO YOU HAVE ANY RESTRICTION THAT PREVENTS YOU FROM TRAVELING OUTSIDE OF THE AREA IF REQUIRED? YES NO
- WHAT IS YOUR BEST ROOFING SKILL - DESCRIBE?

- WHAT WORK EXPERIENCE DO YOU HAVE BESIDES OF ROOFING?

- LIST AND DESCRIBE ANY OTHER CONSTRUCTION EXPERIENCE:

- LIST EDUCATION, TRAINING, OR SKILLS RELATED TO CONSTRUCTION WORK (SAFETY TRAINING, COLLEGE COURSES, TRADE SCHOOL):

CLASS	CERTIFICATE DATE	SCHOOL / PROGRAM

- WHAT LEVEL OF EDUCATION HAVE YOU COMPLETED?

10TH – 11TH GRADE DIPLOMA GED COLLEGE _____

- DO YOU SPEAK ENGLISH? YES NO
- DO YOU UNDERSTAND ENGLISH? YES NO
- DO YOU READ AND WRITE ENGLISH? YES NO
- DO YOU SPEAK SPANISH? YES NO

I CERTIFY THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE AND ACCURATE.

(SIGNATURE)

(DATE)

WEATHERCRAFT COMPANY IS AN EQUAL OPPORTUNITY EMPLOYER

Applicants and employees who wish to benefit under the affirmative action program of WEATHERCRAFT CO. OF COLORADO SPRINGS are invited to identify themselves. This information is voluntarily provided. It will be kept confidential, and refusal to provide it will not subject any applicant or employee to any adverse treatment. Nothing shall preclude employee from informing the company, at a desire under this program.

DO YOU DESCRIBE YOURSELF AS?**SPECIAL DISABLED VETERAN**

YES

NO

A veteran who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Veterans Administration for a disability: (A) rated at thirty percent or more, or (B) rated at ten or twenty percent in the case of a veteran who has been determined under Section 1506 of Title 38 USC to have a serious employment handicap; (2) A person who was discharged or released from active duty because of service-connected disability.

VETERAN OF VIETNAM ERA

YES

NO

A veteran, any part of whose active military, naval or air service was during the period August 5, 1964 through May 7, 1975, who:

- (1) Served on active duty for a period of more than 180 days and was discharged or released there from with other than a dishonorable discharge, or (2) was discharged or released from active duty because of a service-connected disability. No veteran may be considered to be a veteran of the Vietnam Era under this paragraph after December 31, 1997.

HANDICAPPED

YES

NO

Any person who (1) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) has a record of such impairment, or (3) is regarded as having such impairment. For purposes of the part, a handicapped individual is "substantially limited" if he or she is likely to experience difficulty in securing, retaining or advancing in employment because of a handicap.

MINORITY

BLACK

HISPANIC

ASIAN

AMERICAN INDIAN

OTHER

OTHER

MALE

FEMALE

USAFA ACCESS QUESTIONNAIRE

The information on this form is being collected in accordance with, federal law permitting the installation commander to limit access to the installation for security reasons (50 U.S.C. Section 797 and DoD Directive 5200.8). This data will be used to screen individuals who have or are seeking access to the US Air Force Academy. Failure to provide truthful, complete and accurate responses may be used as a basis to deny entry to the US Air Force Academy and is also punishable as a criminal offense.

Please answer each question by circling the correct answer. The information you provide will be verified through state and federal criminal history record checks prior to receiving access to the United States Air Force Academy.

HAVE YOU EVER BEEN CONVICTED OR FOUND NOT GUILTY BY REASON OF INSANITY IN ANY JURISDICTION OR COUNTRY OF ANY OF THE CRIMES LISTED BELOW? (INCLUDE BOTH FELONY AND MISDEMEANOR CONVICTIONS).

	YES	NO
MURDER, MANSLAUGHTER OR UNJUSTIFIED KILLING		
ASSAULT WITH INTENT TO COMMIT MURDER		
ESPIONAGE		
PLOTTING TO OVERTHROW THE US GOVERNMENT		
KIDNAPPING OR HOSTAGE TAKING		
TREASON		
SEXUAL ASSAULT OR ABUSE OF A CHILD		
RAPE OR AGGRAVATED SEXUAL ASSAULT		
UNLAWFUL POSSESSION, USE, SALE, DISTRIBUTION, OR MANUFACTURE OF AN EXPLOSIVE OR WEAPON		
EXTORTION		
ILLEGAL POSSESSION OF A CONTROLLED SUBSTANCE		
DISTRIBUTION OR INTENT TO DISTRIBUTE A CONTROLLED SUBSTANCE		
IMPORTATION OR MANUFACTURE OF A CONTROLLED SUBSTANCE		
ARMED OR UNARMED ROBBERY		
ARSON		
COMMUNICATING A THREAT		
WILLFUL DESTRUCTION OF PROPERTY VALUED OVER \$100		
BURGLARY		
THEFT OF MORE THAN \$100		
DISHONESTY, FRAUD, OR MISREPRESENTATION OVER \$100		
POSSESSION OR DISTRIBUTION OF STOLEN PROPERTY		
AGGRAVATED ASSAULT, ASSAULT WITH A WEAPON		
BRIBERY		
VIOLENCE AT INTERNATIONAL AIRPORTS (18 USC 37)		

MOTOR VEHICLE REPORT – INFORMATION RELEASE

Possession of a valid Colorado Driver's License is favorable to your consideration for employment. Our insurance provider will determine your eligibility to drive for Weathercraft Company. Completing the authorization form below, allows our insurance provider to obtain and review a Motor Vehicle Report.

FEDERAL DRIVER PRIVACY PROTECTION ACT

I, _____, authorize *Weathercraft Co. of Colorado Springs* to obtain my motor vehicle report from CB Insurance, Inc. I understand that this record may contain personal information including, but not limited to, child support payments, alimony payments, as well as, information on driving violations and accidents.

Signature

Date

Driver's License Number

State Licensed Issued

Date of Birth

**CONFIDENTIAL POST JOB OFFER/PRE-PLACEMENT MEDICAL QUESTIONNAIRE
TO BE COMPLETED BY ALL PERSONS OFFERED POSITION PRIOR TO STARTING WORK:**

Job offers are conditioned upon completion of this Medical Questionnaire. This Questionnaire is used to assist us in hiring employees to positions suited to any physical or medical limitations they may have and to establish basic information regarding your physical condition before you begin working. This information will be maintained in a confidential medical file and will not be used to deny any employment opportunities, except in accordance with applicable law.

In the event your response to these questions raises concerns on our part that you cannot safely perform an essential function of the job you have been conditionally offered, we reserve the right to require medical verification of your ability to perform these functions before you are allowed to begin working. We also reserve the right to withdraw your job offer if further inquiry reveals that you cannot safely perform the essential functions of that job. If you qualify as a “disabled person”, this determination will be made after any reasonable accommodation obligations have been satisfied.

PLEASE COMPLETE THIS QUESTIONNAIRE AND SIGN AND DATE IT. INCOMPLETE OR UNSIGNED QUESTIONNAIRES WILL RESULT IN WITHDRAWAL OF YOUR EMPLOYMENT OFFER. FOR EACH “YES” ANSWER, EXPLAIN YOUR ANSWER AT THE END OF THE QUESTIONNAIRE. IF, FOR ANY REASON, YOU ARE UNCERTAIN OF AN ANSWER, INDICATE SO AND BRIEFLY EXPLAIN WHY. DO NOT COMPLETE THIS FORM UNLESS YOU HAVE ALREADY BEEN OFFERED EMPLOYMENT, BUT HAVE NOT YET STARTED WORK.

A. As a result of injury, illness, or other cause, do you have any impairment of:

- | | | |
|--|-----|----|
| 1. Hands that limit dexterity or your ability to maintain a strong grip or hold objects firmly? | YES | NO |
| 2. Arm, wrist, back, shoulder or other problems which limits normal range of motion, full use or strength of your upper extremities? | YES | NO |
| 3. Ankle, knee, foot, leg, or other problems which limit normal range of motion or your ability to stand, walk, squat, kneel, climb stairs, get into and out of vehicles or equipment, or walk on uneven surfaces? | YES | NO |
| 4. The neck or back which interferes with bending or rotation of your neck, or which interferes with your ability to hold your head in fixed positions for prolonged periods of time? | YES | NO |
| 5. The back which interferes with your ability to bend, twist, or flex your back frequently? | YES | NO |
| 6. The back which interferes with your ability to lift or carry objects on a repetitive basis? | YES | NO |
| 7. The joints resulting from stiff, painful, or swollen joints or broken bones? | YES | NO |
| 8. Vision in either eye that interferes with your ability to read, see at a distance, distinguish colors, or see in dim light? | YES | NO |
| 9. Hearing that interferes with your ability to understand spoken words, hear safety alarms or sirens, or requires you to avoid exposure to excessive noise? | YES | NO |

B. As a result of injury, illness or other cause, do you have any impairment which may:

- | | | |
|---|-----|----|
| 1. Affect your equilibrium or ability to maintain your balance? | YES | NO |
| 2. Alter your normal state of consciousness or cause you to become unconscious? | YES | NO |
| 3. Make it dangerous for you to work at unguarded hazardous heights or around moving machinery? | YES | NO |
| 4. Prohibit you from driving licensed company vehicles on public highways? | YES | NO |
| 5. Prohibit you from working alone, at heights, or in confined spaces? | YES | NO |

C. Have you ever:

- | | | |
|--|-----|----|
| 1. Had fainting spells, loss of consciousness, seizures, or epilepsy? | YES | NO |
| 2. Been treated for shortness of breath, emphysema, or other respiratory problems? | YES | NO |
| 3. Had a heart attack, stroke, other heart or circulatory system disease or failure, or high or low blood pressure? | YES | NO |
| 4. Had an illness which affected your nervous system? | YES | NO |
| 5. Had any kind of back problems or any history of back pain? | YES | NO |
| 6. Had back surgery or been treated for a back condition? | YES | NO |
| 7. Had a rupture or hernia? | YES | NO |
| 8. Received a permanent disability award (including any amount of permanent partial disability) for a job or non-job related accident or illness? (Note: We are not interested in knowing whether you have ever had a temporary disability or whether you have ever applied for workers' compensation. The information requested applies only to <i>permanent</i> restrictions). | YES | NO |
| 9. Been exposed to hazardous materials or radioactive substances? | YES | NO |

D. Are you:

- | | | |
|--|-----|----|
| 1. Currently taking any prescription medication which has side effects that could cause drowsiness or affect your ability to safely perform job duties? (Note: We are not interested in knowing whether you are taking prescribed medication that does not cause drowsiness or other side effects that could affect job safety.) | YES | NO |
| 2. Allergic to inhalants (dust, etc.) fumes, solvents, gasoline products, or other substances commonly found in the work place in our industry? | YES | NO |

E. For first aid purposes:

- | | | |
|--|-----|----|
| 1. Do you have any medical condition that we should know about in order to properly administer first aid to you? (For example, a floating sternum that would cause us to avoid giving CPR; allergies to common first aid medication, etc.) | YES | NO |
| 2. If you are a diabetic or have another medical condition that currently requires special treatment from the Company, please advise. (For example, if you are required to be off work to undergo kidney dialysis, etc.) | YES | NO |

F. Do you have any limitations on your ability to perform the duties or the job you have been conditionally offered? (See attached job description)

YES NO

If "YES", identify nature of limitations and provide any recommendations you have for accommodations:

LIST THE LETTER AND NUMBER FOR EACH QUESTION YOU MARKED "YES" AND EXPLAIN.
(ASK FOR ADDITIONAL SHEET IF NECESSARY)

EMERGENCY INSTRUCTIONS:**In case of emergency contact:**

Name

Phone Number

Relationship

City/State

Are there any other emergency instructions, circumstances, medial needs, allergic response or procedure the company should know? PLEASE LIST BELOW.

YES

NO

THE ABOVE ANSWERS (PAGES 3 – 8) ARE TRUE AND CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSIFICATIONS, MISREPRESENTATIONS, OR OMISSIONS, DETERMINED TO BE MATERIAL BY THE COMPANY, MAY RESULT IN WITHDRAWAL OF MY CONDITIONAL EMPLOYMENT OFFER OR DISCHARGE REGARDLESS OF HOW OR WHEN DISCOVERED.

Printed Name

Signature

Date