

APPLICATION FOR EMPLOYMENT

An Equal Opportunity Employer. All applicants will be treated fairly in conformity with all existing federal and state laws. In answering the questions below, if you have any doubt as to the propriety or legality, ask the Personnel Office for an explanation of the questions. If you are still in doubt, do no answer.

PERSONAL

Name _____ Date _____
Last First M.I.

Present Address _____
Street Address City State/Zip Code

Home Telephone() _____ Business Telephone() _____

S.S.# _____

Are you at least 18 years of age? Yes ___ No ___

Do you have the legal right to remain and work in the United States? ___ Yes ___ No

Type of Visa (if applicable) _____

Have you been convicted of any crime other than a minor traffic offense within the last five years? ___ Yes ___ No If yes, nature of crime, when, where and disposition of case (conviction of a crime is not an automatic bar to employment

GENERAL

Position Applying for _____

Salary Desired _____ Date Available for Work _____

How were you referred to this organization? _____

Do you have any friends or relatives in our employ? ___ Yes ___ No

Name(s) _____ Relationship _____

Have you ever worked for this organization before? ___ Yes ___ No

If yes, give details:

Dates _____ Position _____

This application is current only for thirty (30) days, at the conclusion of which time, if you have not heard from us and still wish to be considered for employment, it will be necessary for you to fill out a new application.

EMPLOYMENT HISTORY

Most Recent or Present Employer

Name of Company _____ From _____ To _____

Address _____ Phone() _____

Your Job Titles and Duties _____

Supervisor _____ Starting Pay _____ Ending Pay _____

Reason for Leaving _____

Next Previous Employer

Name of Company _____ From _____ To _____

Address _____ Phone() _____

Your Job Titles and Duties _____

Supervisor _____ Starting Pay _____ Ending Pay _____

Reason for Leaving _____

Next Previous Employer

Name of Company _____ From _____ To _____

Address _____ Phone() _____

Your Job Titles and Duties _____

Supervisor _____ Starting Pay _____ Ending Pay _____

Reason for Leaving _____

Next Previous Employer

Name of Company _____ From _____ To _____

Address _____ Phone() _____

Your Job Titles and Duties _____

Supervisor _____ Starting Pay _____ Ending Pay _____

Reason for Leaving _____

EDUCATION

	Name & Location	Course of Study	Did You Graduate? Degree Received?
HIGH SCHOOL	_____	_____	_____
COLLEGE	_____	_____	_____
TRADE/TECHNICAL	_____	_____	_____
SCHOOL	_____	_____	_____
OTHER	_____	_____	_____

MILITARY SERVICE

Branch of Service _____ From _____ To _____

Rank at Time of Discharge _____

Description of Duties _____

HEALTH INFORMATION

Do you have any physical or mental impairments that would interfere with you ability to perform the job applied for? _____ Yes _____ No

If yes, please explain: _____

In case of emergency, notify:

Name _____ Telephone Number(_____)

Address _____

CERTIFICATION

I certify that the information contained in this application is correct to the best of my knowledge and understand that falsification or misrepresentation is grounds for dismissal in accordance with D.G. FOWLER ELECTRIC COMPANY'S policy.

I authorize the references listed in this application to give you any and all information that they may have, and release all parties from liability for any damage that may result from furnishing same to you.

In consideration of my employment, I agree to conform to the rules and regulations of D.G. FOWLER ELECTRIC COMPANY, INC. and my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at the option of either the Company or myself and without notice or liability for wages or salary except such earned at the date of such termination. I understand that no manager, supervisor or representative of management, other than the president (or vice president) has authority to enter into an agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing.

Applicant's Signature _____ Date _____

INTERVIEW RECORD (To Be Completed by Employer)

DATE	COMMENTS
_____	_____
_____	_____
_____	_____
_____	_____

EMPLOYMENT INFORMATION (To Be Completed by Employer)

Starting Date _____ Employee Number _____

Position/Title _____ Shift _____

Department _____ Salary Grade _____

Rate of Pay _____

MEDICAL HISTORY QUESTIONNAIRE:

It is the policy of this company, not to discriminate against employees suffering from any physical or mental condition resulting from injury or illness. It is very important that you provide complete and accurate information concerning any physical and/or mental problems you may have. This will allow us to determine what job may be appropriate for you in order to prevent injury to you or any of your co-workers. This information is necessary in the event that you should have an additional injury on the job so that we may recover from the Subsequent Injury Trust Fund a portion of worker's compensation benefits paid to you. Failure to provide this information may affect your rights to recover worker's compensation benefits for any injury/illness arising out of and in the course of your employment with us.

PLEASE PRINT YOUR ANSWERS TO THE FOLLOWING QUESTIONS:

1. Do you have a physical or mental condition which you believe is or may be permanent? _____

If yes, please describe the condition; _____

2. What physical activity (s) or job activity (s) might this medical condition make more difficult? _____

3. Do you smoke? _____

4. If you have had any surgical procedures; please briefly describe them here and include approximate date of occurrence. _____

5. Do you suffer from, or have you ever been diagnosed as having any of the illnesses/diseases listed below: (please check all that apply)

Epilepsy _____
Diabetes _____
Arthritis _____
Polio _____
Hearing Loss _____
Sight Loss in one or
Both eyes _____
Muscular
Dystrophy _____

Mental Retardation _____
or Mental Illness _____
Amputation of foot,
leg, hand or arm _____
Cerebral Palsy _____
Hyperinsulism _____
Parkinson's Disease _____
Ruptured Intervertebral
Disc. _____

Hemophilia _____
Sickle Cell Anemia _____
Osteomyelitis _____
Ankylosis (of major weight
bearing joints) _____
Multiple Sclerosis _____
Heart or cardiovascular
Condition _____
Compressed Air Sequelae _____

Any other medical condition: _____

Applicant/Employee Print Name

Signature

Date

PREVIOUS EMPLOYMENT VERIFICATION

TO: _____

RE: _____
SS# _____
Who states he/she was employed by
Your firm
FROM _____ TO _____
CAPACITY OF _____

To assist us in evaluating this applicant's qualifications, please answer the questions below and provide any comments you feel may be helpful. All information will be held in strict confidence. Please note the signed release below. A self-addressed, stamped envelope is enclosed for your convenience in replying to this inquiry.

1. Are the dates of employment shown above correct? _____ Yes _____ No
If NO: _____ to _____
2. Reason for separation: _____ Termination _____ Layoff _____ Resigned
Please describe circumstances: _____

3. Please evaluate this person using the following chart:

Excellent Very Good Good Fair Poor

Quality of Work _____

Quantity of Work _____

Cooperation _____

Job Knowledge _____

Attendance _____

Attitude _____

4. How did you classify this person? _____ Electrician
or _____ Apprentice (Yr 1, 2, 3, 4) circle one
5. If your firm affiliated with any union? _____ Yes _____ No
6. Has this person filed any Worker's Compensation claims while in your
Employ? _____ Yes _____ No
If yes, please give the nature of the injury: _____

Remarks: _____

APPLICANT RELEASE:

Having made application for consideration of employment with D.G. Fowler Electric Company, Inc., I request that their representative be informed as to my previous work record. I hereby authorize the investigation of my past employment, whether same is of record or not. I release my employers and all persons whomsoever of any damages resulting from furnishing said information.

Signature: _____
Printed Name: _____
Date: _____

PRE-EMPLOYMENT DRUG SCREENING
AND CONDITIONAL EMPLOYMENT AGREEMENT

As you know, the Pre-employment Physical may be part of D.G. FOWLER ELECTRIC CO., INC.'s overall pre-employment procedures which enable our company to analyze your eligibility for employment. One of the requirements for consideration of employment with D.G. FOWLER ELECTRIC CO., INC. is the satisfactory passing of the Company's **URINE DRUG SCREEN TEST**. Please read and answer the following instructions and information carefully:

Applicant:

I am presently taking, or have taken the following drug/medication (prescription/non-prescription):

- | | |
|----------|-------------------|
| 1. _____ | Last Taken: _____ |
| 2. _____ | Last Taken: _____ |
| 3. _____ | Last Taken: _____ |

NOTICE: D.G. FOWLER ELECTRIC CO., INC. HAS A POLICY PROHIBITING THE POSSESSION AND/OR USE OF ILLEGAL AND UNAUTHORIZED DRUGS, AND PERIODICALLY SEARCHES AND URINE SCREENS ITS EMPLOYEES AS AN ENFORCEMENT MEASURE IN PROVIDING A SAFE WORKING ENVIRONMENT. YOU MAY BE DROPPED FROM CONSIDERATION OF EMPLOYMENT WITH OUR COMPANY IF THE RESULTS OF YOUR URINE DRUG SCREEN INDICATE THAT YOU ARE APPLYING FOR A JOB WHILE YOU ARE USING ANY OF THE ABOVE MENTIONED ILLEGAL OR UNAUTHORIZED DRUGS.

(The applicant may choose to have a second methodology test performed on the same positive urine sample; however, the second test must be paid for by the applicant and requested within 24 hours after being disqualified).

APPLICANT:

I have read and understood this phase of D.G. FOWLER ELECTRIC CO., INC.'s pre-employment medical requirements as explained to me on Policy Form PS101. I accept D.G. FOWLER ELECTRIC CO., INC. conditions for consideration of employment and consent to the requirements of both the urine drug screen and other pre-employment physical examinations. I also acknowledge that under certain circumstances an applicant may be permitted to conditionally begin working for D.G. FOWLER ELECTRIC CO., INC. even if the results of such medical test or urine drug screen are not complete. I further understand that this type of employment is conditional until such time that the company receives satisfactory test results indicating my complete fitness for duty status as a regular employee. I also understand that my conditional employment may be immediately terminated and that I will be paid for only actual time worked if the results of such test indicates that I have applied for this position while I was using any of the above mentioned illegal or unauthorized drugs or substances.

I agree in submitting to this medical test that the testing agency is authorized by me to provide the results of this test to D.G. FOWLER ELECTRIC CO., INC. I further agree to hold the Company, its agents, directors, officers, owners and employees harmless from any and all liability in connection with the testing for drug and/or alcohol content.

Print Applicant Name Here

Applicant Signature

Date

Witness Signature

Date

PRE-EMPLOYMENT DRUG SCREENING
AND CONDITIONAL EMPLOYMENT AGREEMENT

As you know, the Pre-employment Physical may be part of D.G. FOWLER ELECTRIC CO., INC.'s overall pre-employment procedures which enable our company to analyze your eligibility for employment. One of the requirements for consideration of employment with D.G. FOWLER ELECTRIC CO., INC. is the satisfactory passing of the Company's **URINE DRUG SCREEN TEST**. Please read and answer the following instructions and information carefully:

Applicant:

I am presently taking, or have taken the following drug/medication (prescription/non-prescription):

1. _____ Last Taken: _____
2. _____ Last Taken: _____
3. _____ Last Taken: _____

NOTICE: D.G. FOWLER ELECTRIC CO., INC. HAS A POLICY PROHIBITING THE POSSESSION AND/OR USE OF ILLEGAL AND UNAUTHORIZED DRUGS, AND PERIODICALLY SEARCHES AND URINE SCREENS ITS EMPLOYEES AS AN ENFORCEMENT MEASURE IN PROVIDING A SAFE WORKING ENVIRONMENT. YOU MAY BE DROPPED FROM CONSIDERATION OF EMPLOYMENT WITH OUR COMPANY IF THE RESULTS OF YOUR URINE DRUG SCREEN INDICATE THAT YOU ARE APPLYING FOR A JOB WHILE YOU ARE USING ANY OF THE ABOVE MENTIONED ILLEGAL OR UNAUTHORIZED DRUGS.

(The applicant may choose to have a second methodology test performed on the same positive urine sample; however, the second test must be paid for by the applicant and requested within 24 hours after being disqualified).

APPLICANT:

I have read and understood this phase of D.G. FOWLER ELECTRIC CO., INC's pre-employment medical requirements as explained to me on Policy Form PS101. I accept D.G. FOWLER ELECTRIC CO., INC. conditions for consideration of employment and consent to the requirements of both the urine drug screen and other pre-employment physical examinations. I also acknowledge that under certain circumstances an applicant may be permitted to conditionally begin working for D.G. FOWLER ELECTRIC CO., INC. even if the results of such medical test or urine drug screen are not complete. I further understand that this type of employment is conditional until such time that the company receives satisfactory test results indicating my complete fitness for duty status as a regular employee. I also understand that my conditional employment may be immediately terminated and that I will be paid for only actual time worked if the results of such test indicates that I have applied for this position while I was using any of the above mentioned illegal or unauthorized drugs or substances.

I agree in submitting to this medical test that the testing agency is authorized by me to provide the results of this test to D.G. FOWLER ELECTRIC CO., INC. I further agree to hold the Company, its agents, directors, officers, owners and employees harmless from any and all liability in connection with the testing for drug and/or alcohol content.

Print Applicant Name Here

Applicant Signature

Date

Witness Signature

Date

STATEMENT OF BENEFITS

HEALTH CARE FOR YOU AND YOUR FAMILY

The company provides a major medical health insurance program with coverage for each eligible employee and their dependents. The company pays for the majority of the costs associated with the plan, and the employee will pay a small portion, to be deducted weekly. The cost to you, the employee, is shown below and is subject to change as circumstances warrant. Employees are eligible for this program ninety (90) days after employment (provided the enrollment card is promptly completed and returned). A detailed information book and identification card will be provided at the time coverage begins.

If you have any questions concerning health insurance coverage, limits or outstanding claims, feel free to call the customer service department of our carrier directly.

Currently, your cost for insurance coverage will be:

EMPLOYEE ONLY	\$ 32.96 per week
EMPLOYEE & 1 Dependant	\$ 65.93 per week
FAMILY w/ 1 Child	\$ 65.93 per week
Family w/ 2 Children	\$ 98.89 per week
Family w/ 3 Children	\$ 98.89 per week

CONTINUATION OF COVERAGE

Employees are eligible for continuation of health insurance benefits in accordance with current state and federal laws upon termination from the company or other qualifying events. Please be sure to request the appropriate forms upon termination, divorce or other qualifying event.

VOLUNTARY LIFE INSURANCE FROM HARTFORD: Ask the office for enrollment information.

DENTAL INSURANCE – METLIFE INSURANCE COMPANY

EMPLOYEE ONLY	\$ 7.30 per week
EMPLOYEE & SPOUSE	\$16.23 per week
EMPLOYEE & CHILDREN	\$17.45 per week
FAMILY	\$25.07 per week

ALL RATES ARE SUBJECT TO CHANGE PER CURRENT INSURANCE CARRIER

Revised: November 2, 2012

STATEMENT OF BENEFITS – continued

PAID VACATION PROGRAM

Field employees, of our firm, will receive paid vacation days in accordance with the following schedule:

After two (2) full years of service	five (5) days per calendar year
After six (6) full years of service	eight (8) days per calendar year
After ten (10) full years of service	ten (10) days per calendar year

Conditions:

1. Years of service must be continuous.
2. A day of vacation will be forfeited for each unexcused absence from work.
3. Vacation pay is available only when the time off is requested and approved four (4) weeks in advance. Exception: if you lose time off work as a result of any serious illness or non-job-related injury to you or a member of your immediate family. You must provide a doctor's statement or hospitalization verification in order to qualify for this exception.
4. Unused vacation time will accumulate up to twenty (20) days per calendar year. Unused time beyond twenty (20) days will be forfeited.
5. All time-off and the payment of vacation pay must be pre-approved by company management.

TRAINING PROGRAMS

Employees are encouraged to participate in field related educational opportunities. Apprentices will be required to participate in a four (4) year training program. We provide a tuition assistance program for all qualified programs as follows:

We will reimburse your tuition upon completion of training program (per semester for apprentices) in accordance with the grade you earn.

- For an A - you will be reimbursed 100%
- For a B - you will be reimbursed 80%
- For a C - you will be reimbursed 70%

The company does not reimburse for textbooks or other materials.

BONUS PLAN

After two (2) years of continuous service each employee will be eligible to receive a bonus at the end of each year. This bonus is discretionary based on the earnings each year. It is our desire to reward each employee for the success of the Company.

RETIREMENT PLAN

Each employee is eligible to participate in an S.I.M.P.L.E. Retirement Savings Account in accordance with current Laws and Regulations. The Company will match your contribution up to 3% with a possible reduction to 1% during poor economic situations. This plan is completely in the employee's control (as allowed by current laws) and is transportable should you leave the Company.

MANDATORY EMPLOYMENT INSURANCE

The company provides coverage for Worker's Compensation, Unemployment Insurance and Social Security as required by current law.