P.J. Albert INC
PAVING & EXCAVATING
Telephone 978-345-7828 • 800-370-7828 • Fax 978-345-1425
P.O. Box 2165 • Fitchburg, MA 01420 • www.pjalbert.com

APPLICATION FOR EMPLOYMENT

APPLICANTS FOR EMPLOYMENT ARE CONSIDERED WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, MARITAL STATUS, VETERAN STATUS, NATIONAL ORIGIN, AGE, OR HANDICAP.

1. GENERAL INFORMATION

(PLEASE PRINT)

DATE OF APPLICATION:_____

POSITION(S) APPLIED FOR:_____

HOW DID YOU LEARN OF OUR ORGANIZATION?:_____

NAME:_____

ADDRESS:_____

HOME PHONE:( ) _____ WORK PHONE:( ) _____

ARE YOU EMPLOYED NOW?:_____

ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THE UNITED STATES?:_____

ON WHAT DATE WOULD YOU BE AVAILABLE FOR WORK?:_____

ARE YOU AVAILABLE TO WORK FULL TIME?:_____

WILL YOU WORK OVERTIME IF ASKED?:_____

ARE YOU ON A LAY-OFF AND SUBJECT TO A RECALL?:_____

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

2. EMPLOYMENT EXPERIENCE

START WITH YOUR PRESENT OR LAST JOB. INCLUDE MILITARY SERVICE ASSIGNMENTS. EXCLUDE ANY ORGANIZATION NAMES WHICH INDICATE RACE, COLOR, RELIGION, SEX OR NATIONAL ORIGIN.

EMPLOYER:	EMPLOYED		WORK PERFORMED
ADDRESS:	FROM	TO	
TEL. #:			
JOB TITLE:	HOURLY RATE		
SUPERVISOR:	START	FINAL	
REASON FOR LEAVING:			
EMPLOYER:	EMPLOYED		WORK PERFORMED
ADDRESS:	FROM	TO	
TEL. #:			
JOB TITLE:	HOURLY RATE		
SUPERVISOR:	START	FINAL	
REASON FOR LEAVING:			
EMPLOYER:	EMPLOYED		WORK PERFORMED
ADDRESS:	FROM	TO	
TEL. #:			
JOB TITLE:	HOURLY RATE		
SUPERVISOR:	START	FINAL	
REASON FOR LEAVING:			
EMPLOYER:	EMPLOYED		WORK PERFORMED
ADDRESS:	FROM	TO	
TEL. #:			
JOB TITLE:	HOURLY RATE		
SUPERVISOR:	START	FINAL	
REASON FOR LEAVING:			

IF YOU NEED ADDITIONAL SPACE, PLEASE CONTINUE ON A SEPARATE SHEET OF PAPER.

3. SPECIAL SKILLS, LICENSES AND QUALIFICATIONS

SUMMARIZE ANY SPECIAL SKILLS AND QUALIFICATIONS ACQUIRED FROM PREVIOUS EMPLOYMENT OR OTHER EXPERIENCE. ALSO LIST ANY SPECIAL LICENSES YOU HAVE.

IF APPLYING FOR A TRUCK DRIVER POSITION, ARE YOU AT LEAST 21 YEARS OF AGE?_____YES_____NO

IF APPLYING FOR ANY OTHER POSITION, ARE YOU AT LEASE 18 YEARS OF AGE?_____YES_____NO

DRIVERS LICENSE: STATE_____TYPE_____EXPIRATION DATE_____

THIS LAST PART OF SECTION 3 IS TO BE COMPLETED ONLY IF APPLYING FOR A DRIVING POSITION. NOT FOR INTERVIEW PURPOSES.

LICENSES:

DRIVERS LICENSE HELD IN PAST 3 YEARS MUST BE SHOWN.

STATE	LICENSE NUMBER	CLASS	ENDORSEMENT(S)	EXPIRATION DATE

A. HAVE YOU EVER BEEN DENIED A LICENSE, PERMIT OR PRIVILEGE TO OPERATE A MOTOR VEHICLE?
YES_____ NO_____

B. HAS ANY LICENSE, PERMIT OR PRIVILEGE EVER BEEN SUSPENDED OR REVOKED?
YES_____ NO_____

C. HAVE YOU EVER BEEN DISQUALIFIED FOR VIOLATIONS OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS?
YES_____ NO_____

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN,TANK,FLAT,ETC..)	DATES FROM	TO
STRAIGHT TRUCK			
TRACTOR & SEMI-TRAILER			

LIST STATES OPERATED IN DURING LAST FIVE YEARS:_____

LIST SPECIAL COURSES OF TRAINING THAT WILL HELP YOU AS A DRIVER_____

_____

ACCIDENT REVIEW FOR PAST 3 YEARS (ATTACH SEPARATE SHEET OF PAPER IF NECESSARY)

DATES OF ACCIDENTS	NATURE OF ACCIDENT (HEAD ON, REAR END, ETC..)	FATALITIES	INJURIES

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS OTHER THAN PARKING

LOCATION	DATE	CHARGE	PENALTY

4. EDUCATION

SCHOOL	NAME OF SCHOOL	COURSE OF STUDY	DEGREE OR DIPLOMA
COLLEGE			
HIGH			
OTHER			

5. APPLICANT'S CERTIFICATION AND AGREEMENT

PLEASE READ CAREFULLY

I HEREBY CERTIFY THAT THE FACTS SET FORTH IN THE ABOVE EMPLOYMENT APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE CONSIDERED SUFFICIENT CAUSE FOR DISMISSAL. YOU ARE HEREBY AUTHORIZED TO INVESTIGATE ANY STATEMENTS CONTAINED IN THIS APPLICATION AND THAT THIS EMPLOYMENT APPLICATION OR THE GRANTING OF AN ORAL INTERVIEW DOES NOT REPRESENT A CONTRACT OF EMPLOYMENT OR FUTURE BENEFITS BY THIS COMPANY/ORGANIZATION.

I ALSO UNDERSTAND THAT A POST-OFFER PHYSICAL, INCLUDING A DRUG AND ALCOHOL SCREENING ARE PREREQUISITES TO MY EMPLOYMENT AND I HEREBY CONSENT TO SUCH AN EXAM IN ORDER TO DETERMINE MY ABILITY TO PERFORM THE DUTIES OF THE JOB I AM BEING CONSIDERED FOR.

EMPLOYMENT - AT - WILL

I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF P.J. ALBERT, INC., AND THAT, **IF HIRED, MY EMPLOYMENT WILL BE AT-WILL AND MAY BE TERMINATED WITH OR WITHOUT NOTICE AT ANY TIME AT MY OPTION OR AT THE OPTION OF P. J. ALBERT, INC.** I UNDERSTAND THAT ONLY A WRITTEN AGREEMENT EXPRESSLY TO THE CONTRARY SIGNED BY ME AND THE TREASURER OR VICE PRESIDENT OF P. J. ALBERT, INC., CAN VARY THIS EMPLOYMENT-AT-WILL POLICY.

_____

SIGNATURE OF APPLICANT

_____

DATE

6. NOTICE TO APPLICANTS

P.J. ALBERT, INC., OFFERS EMPLOYMENT CONTINGENT UPON RECEIVING WRITTEN NOTICE THAT THE APPLICANT HAS RECEIVED PASSING RESULTS ON A POST- OFFER PHYSICAL AND DRUG SCREEN THROUGH A DESIGNATED MEDICAL FACILITY. P.J. ALBERT, INC., WILL PAY FOR THESE MEDICAL COSTS, BUT, BY LAW, IS NOT REQUIRED TO PAY FOR THE APPLICANT'S TIME.

UPON RECEIPT OF WRITTEN NOTIFICATION FROM THE MEDICAL FACILITY THAT THE EMPLOYEE IS FIT FOR DUTY, ALL NEWLY HIRED EMPLOYEES WILL GO THROUGH AN ORIENTATION PROGRAM THAT LASTS FOR APPROXIMATELY TWO HOURS. COMPANY POLICIES AND BENEFITS WILL BE EXPLAINED AND NECESSARY PAPERWORK WILL BE COMPLETED.

_____

SIGNATURE OF APPLICANT

_____

DATE

7. REFERENCE RELEASE FORM

PLEASE RESPOND TO ANY REFERENCE INQUIRY AND PROVIDE AN OPINION AS TO MY SUITABILITY FOR EMPLOYMENT WITH P.J. ALBERT, INC BY THIS AUTHORIZATION:

I HEREBY RELEASE YOU FROM ANY AND ALL LIABLILITY FOR PROVIDING THE RECORDS AND INFORMATION BELOW REGARDLESS OF THE TRUTH OR FALSITY THEREOF.

I HEREBY AUTHORIZE THE RELEASE OF MY EMPLOYMENT DATES, EVALUATION OF WORK PERFORMANCE, AND ANY OTHER WORK RELATED INFORMATION TO P.J. ALBERT, INC.

I HEREBY AUTHORIZE P.J. ALBERT, INC. TO RECEIVE AND HAVE TOTAL ACCESS TO THE RECORDS SET FORTH ABOVE, AND RELEASE P.J. ALBERT, INC. FROM ANY AND ALL LIABILITY FROM DAMAGE WHICH MAY RESULT FROM THE AUTHORIZATION CONTAINED WITHIN. I UNDERSTAND THAT THIS INFORMATION WILL BE USED FOR REFERENCE PURPOSES ONLY.

MAY WE CONTACT YOUR PRESENT/ PAST EMPLOYER? YES_____ NO_____

I AM VOLUNTARILY FURNISHING THE IDENTIFYING INFORMATION LISTED ABOVE TO ASSIST YOU IN LOCATING MY RECORDS.

_____
APPLICANT'S NAME (INCLUDE MAIDEN NAME IF APPLICABLE)

_____
SIGNATURE OF APPLICANT

_____
DATE

Voluntary Affirmative Action Data

PLEASE NOTE: Completion of this form is voluntary.
We consider all applicants for positions without regard to race, color, religion, sex, national origin, citizenship, age, mental or physical disabilities, veteran/reserve/ National Guard, or any other similarly protected status. We also comply with all applicable laws governing employment practices and do not discriminate on the basis of any unlawful criteria.

To be completed by applicant on a voluntary basis. Not for interview purposes. File separately from application.
In an effort to comply with requirements regarding government recordkeeping, reporting, and other legal obligations that may apply, we request that you complete this applicant data survey. Providing this information is **STRICTLY VOLUNTARY**. Failure to provide it will not subject you to any negative personnel decision or action. Your cooperation is appreciated.

Applicant Information

Name _____ Phone (_____) _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

☐ Male ☐ Female Position applied for _____ Date ____/____/____

Referral source:

☐ Government Employment Agency ☐ Private Employment Agency ☐ Current Employee
☐ Walk-in ☐ School ☐ Relative
☐ Other _____
☐ Advertisement was seen in _____
Person who referred you, if applicable _____

Please select one of the following Equal Employment Opportunity Identification Groups:

☐ Hispanic or Latino ☐ White (not Hispanic or Latino) ☐ Asian (not Hispanic or Latino)
☐ Native Hawaiian/Other Pacific Islander (not Hispanic or Latino) ☐ Black/African American (not Hispanic or Latino)
☐ American Indian/Alaskan Native (not Hispanic or Latino) ☐ Two or More Races (not Hispanic or Latino)

For Administrative Use

Position(s) applied for _____ ☐ Current opening ☐ No current opening
Other position(s) considered for _____
Hired? ☐ No ☐ Yes Hire date ____/____/____ Position hired for _____

Position classification

☐ Executive/Senior-Level Officials and Managers
☐ First/Mid-Level Officials and Managers
☐ Administrative Support Workers
☐ Professionals
☐ Operatives (semiskilled)
☐ Craft Workers (skilled)
☐ Sales Workers
☐ Service Workers
☐ Technicians
☐ Laborers (unskilled)

Additional notes _____

Completed by _____ Date ____/____/____

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: Date:
Employee ID:
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- ☐ Yes, I have a disability, or have had one in the past
- ☐ No, I do not have a disability and have not had one in the past
- ☐ I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: Date of Hire: