



850 South Guild Ave, Lodi, CA 95240
209.365.6490 | www.fairmontsign.com

Application for Employment

To the Applicant: We appreciate your interest in our company and assure you that we are interested in your qualifications. A clear understanding of your background and work history will aid us in seeking to place you in a position which, in our judgement, best meets your qualifications.

We are an equal opportunity employer and will not unlawfully discriminate on the basis of race, color, sex, religion, national origin, age, marital or veteran status, the presence of a medical condition or handicap, height, weight or any other protected status.

PERSONAL INFORMATION

FULL NAME:		DATE OF APPLICATION:	
ADDRESS:			
CITY:		STATE:	ZIP:
EMAIL ADDRESS:			
PHONE:			
ARE YOU 18 YEARS OR OLDER? Yes <input type="checkbox"/> No <input type="checkbox"/>			
ARE YOU AUTHORIZED TO WORK IN THE UNITED STATES? Yes <input type="checkbox"/> No <input type="checkbox"/>			
HAVE YOU BEEN PREVIOUSLY EMPLOYED HERE? Yes <input type="checkbox"/> No <input type="checkbox"/> IF YES, DATE(S):			
SUPERVISOR NAME(S)			
HAVE YOU FILED AN APPLICATION WITH THIS COMPANY BEFORE? Yes <input type="checkbox"/> No <input type="checkbox"/> IF YES, DATE(S):			
LIST ANY FRIENDS OR RELATIVES WORKING HERE:			
POSITION(S) APPLYING FOR:			
HOW DID YOU HEAR ABOUT THIS POSITION?			
KIND OF WORK DESIRED: Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Other <input type="checkbox"/>			
DO YOU HAVE ANY SPECIAL TRAINING, SKILLS, QUALIFICATIONS OR OTHER EXPERIENCES THAT RELATE TO THIS POSITION(S)?			
SALARY DESIRED:		DATE AVAILABLE TO WORK:	

Employers must make accommodations to disabled applicants and employees where the accommodation does not impose an undue hardship on the employer.

Under Michigan law, disabled employees and applicants may request an accommodation of their disability by notifying the company in writing of the need for accommodation within 182 days of the date the disabled individual knows or should know that an accommodation is needed. Failure to properly notify the company may preclude any claim that the employer failed to accommodate the disabled individual.

EMPLOYMENT EXPERIENCE (List current or most recent job first)

1	Company:			Phone:		
	Address:	City	State	Zip		
	Job Title:				DATES OF EMPLOYMENT	
					From:	To:
	Supervisor's Name:					
	Responsibilities:					
	Reason for Leaving:					

2	Company:			Phone:		
	Address:	City	State	Zip		
	Job Title:				DATES OF EMPLOYMENT	
					From:	To:
	Supervisor's Name:					
	Responsibilities:					
	Reason for Leaving:					

3	Company:			Phone:		
	Address:	City	State	Zip		
	Job Title:				DATES OF EMPLOYMENT	
					From:	To:
	Supervisor's Name:					
	Responsibilities:					
	Reason for Leaving:					

4	Company:			Phone:		
	Address:	City	State	Zip		
	Job Title:				DATES OF EMPLOYMENT	
					From:	To:
	Supervisor's Name:					
	Responsibilities:					
	Reason for Leaving:					

AUTHORIZATION AND UNDERSTANDING:

Upon signing of this application, I represent that all of the information now or hereafter given by me in support of my application is true and complete. I authorize you to verify any of the information concerning my employment, education, criminal history, medical history (post-off only), or credit history with the appropriate individuals, companies, institutions or agencies, and I authorize them to release such information as you require, including my prior disciplinary employment record, without any obligation to give me written notice of such disclosure. I hereby release you and them from any liability whatsoever as a result of any such inquiries and disclosures. I agree that any false information in support of my application may subject me to discharge at any time during the period of my employment.

I agree that either party may terminate the employment relationship, with or without cause, at any time, and I further agree that this arrangement may only be altered in writing directed to me personally and signed by the president of the company.

I agree that I shall be bound by the other rules, policies, regulations and terms and conditions of employment of the company as they are from time to time changed, and no additional obligations can be imposed on the company except those which have been acknowledged in writing, by the president or his designated representatives. I hereby authorize the company to deduct from each and every period of my pay any amounts necessary to offset any damages caused by me or the value of property or money entrusted to me by, or owed by me to, the company during the course of my employment.

I agree that any action or suit against the company arising out of my employment or termination of employment, including, but not limited to, claims arising under State or Federal civil rights statutes, must be brought within 180 days of the event giving rise to the claims or be forever barred. I waive all limitation periods to the contrary. Should the 180 day limitations period be found to be unreasonable and unenforceable, the period of limitations shall be a minimum reasonable time in excess of 180 days. I further agree that if I should bring any non-statutory action or claim arising out of my employment against the company, in which the company prevails, I will pay to the company any and all such costs incurred by the company in defense of said claims or actions, including attorney fees. I further agree that my employment is conditional until such time as the results of my post-offer physical (if such physical is required) are known.

By checking the box you are signing this application electronically.

Signature _____ Date: _____

INTERVIEWED BY:			DATE:
COMMENTS:			
HIRED			
Yes <input type="checkbox"/>	No <input type="checkbox"/>	STARTING DATE:	DEPARTMENT:
JOB TITLE:		RATE OF PAY:	
COMMENTS:			
APPROVED			
NAME	TITLE	DATE	