

**JOE MURDAUGH MASONRY  
APPLICATION QUESTIONNAIRE  
AN EQUAL OPPORTUNITY EMPLOYER**

DATE:	S.S. #:	POSITION APPLYING FOR:
PLEASE PRESENT YOUR SOCIAL SECURITY CARD & ONE OTHER FORM OF IDENTIFICATION		SALARY EXPECTED:
		DATE AVAILABLE:

**PERSONAL DATA:** IT IS IMPORTANT THAT YOU ANSWER ALL QUESTIONS CORRECTLY AND COMPLETELY.

NAME: \_\_\_\_\_ OTHER NAMES: \_\_\_\_\_  
 (Last Name) (First Name) (Middle Initial) (Nickname or maiden)

ADDRESS: \_\_\_\_\_  
 (Number) (Street) (City) (State) (Zip Code)

TELEPHONE: \_\_\_\_\_ RELATIVES EMPLOYED AT THIS COMPANY: \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

**EMPLOYMENT HISTORY:** List chronologically all employments, including summer and part-time.

NAME and ADDRESS OF EMPLOYER	FROM	TO	SALARY		SUPERVISOR	REASON FOR LEAVING
			BEG.	END.		
Name Phone						
Name Phone						
Name Phone						
Name Phone						
Name Phone						
Name Phone						
Name Phone						

May we contact your present employer? Yes \_\_\_ No \_\_\_ If No, please explain \_\_\_\_\_

List any correspondence courses, seminars, workshops, training sessions, etc. that might relate to this position.  
 Also list any licenses or certificates relating to position or any other skills or experience which better qualifies you for position.

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ACTIVE DUTY IN U.S. ARMED FORCES: YES NO	DATE OF DUTY: FROM TO	BRANCH:
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**EDUCATION INFORMATION**

Circle highest grade completed:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Post Graduate		
																BS/BA	MA	PHD	
Name and address of last High School:																	Have you passed GED Test?		
																	Yes	No	

TYPE SCHOOL	NAME AND ADDRESS OF SCHOOL	DEGREE	MAJOR
College/ University			
College/ University			
Graduate			
Technical			
Military			

HAVE YOU EVER BEEN EMPLOYED BY THIS COMPANY? YES \_\_\_\_\_ NO \_\_\_\_\_ WHERE \_\_\_\_\_ WHEN \_\_\_\_\_ JOB \_\_\_\_\_

HAVE YOU BEEN CONVICTED OF A FELONY? YES \_\_\_\_\_ NO \_\_\_\_\_ OFFENSES: \_\_\_\_\_

DETAIL OF COURT ACTION: \_\_\_\_\_  
 (Date) (Place) (Disposition)

**STATEMENT OF WAIVER:**

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for dismissal, further, I understand and agree that employment is for no definite period; and may, regardless of the date of payment of my wages and salary, be terminated at any time without any previous notice. I further understand and agree, that, by accepting employment, the Company may elect to transfer me to other locations, and on other shift assignments.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**PERSONNEL USE ONLY**

**INTERVIEW SUMMARY:**

Was Applicant Hired? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If not, why? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DISPOSITION IF HIRED:**

Pay Rate: \_\_\_\_\_  
 Start Date: \_\_\_\_\_  
 Job Title: \_\_\_\_\_  
 Authorizing Signature: \_\_\_\_\_

## Post-Offer Medical Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Name of Doctor(s) Normally Used? \_\_\_\_\_

Home Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Last Physical Exam: \_\_\_\_\_

Examining Physician: \_\_\_\_\_

Are you (check one)  right  left handed

No	Yes	When	Check items which apply to you	No	Yes	When	
			Scarlet Fever				Diphtheria
			Swollen or Painful Joints				Rheumatic Fever
			Whooping Cough				Mumps
			Frequent, Severe Headaches				Dizziness, Fainting Spells
			Ear, Nose, Throat Trouble				Eye Trouble
			Chronic or Frequent Colds				Running Ears
			Severe Tooth or Gum Trouble				Hay Fever
			Goiter				Tuberculosis
			Shortness of Breath				Asthma
			Pain or Pressure in Chest				Chronic Cough
			Palpitation, Pounding Heart				Cramps in Your Legs
			High or Low Blood Pressure				Frequent Indigestion
			Stomach, Liver, Intestinal Trouble				Gall Bladder Trouble
			Jaundice				Gall Stones
			Tumor, Growth, Cyst, Cancer				Rupture
			Frequent or Painful Urination				Appendicitis
			Kidney Stone or Blood in Urine				Piles or Rectal Disease
			Veneral Disease				Recent Gain or Loss of Weight
			Bone, Joint, Other Deformity				Boils
			Loss of Arm, Leg, Finger, Toe				Arthritis or Rheumatism
			Painful or "Trick" Shoulder or Elbow				Lameness
			Paralysis				"Trick" or Locked Knee
			Nervous Trouble of any Sort				Foot Trouble
			Any Drug or Narcotic Habit				Neuritis
			Excessive Drinking Habit				Epilepsy or Seizures
							Coughed Up Blood
Have You Ever? (Check Each Item)							
			Worn Glasses				Worn Hearing Aids
			Worn an Artificial Eye				Worn Artificial Limbs
			Worn a Brace or Back Support				

Answer Each Item

Yes No

Have You-	Yes	No
Ever been denied life insurance?		
Had an operation or been advised to have an operation?		
Been a patient (committed or voluntary) in a mental hospital or sanitarium?		
Consulted or been treated by clinics, physicians, healers, within 5 years?		
Had heart trouble of any kind?		
Had back trouble of any kind?		
Ever received, is there pending, have you ever applied for, or do you intend to apply for pension or compensation, or workers' compensation for an existing disability.		

*If you answer "Yes" to any questions, attach additional pages if necessary.*

I hereby certify that the information given by me in this medical history is true in all respects and I agree that if employed, and it is found to be false in any respect, that I will be subject to dismissal without notice.

I authorize any of the doctors, hospitals, or clinics mentioned above to furnish to the company a complete transcript of my medical records.

Signature: \_\_\_\_\_