

Application for Employment Armour Tight Gunite, LLC

WE CONSIDER ALL APPLICANTS FOR POSITIONS WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, AGE, MARITAL OR VETERAN STATUS, THE PRESENCE OF A NON-JOB RELATED MEDICAL CONDITION OR HANDICAP, OR ANY OTHER LEGALLY PROTECTED STATUS.

Position(s) Applying for _____ Date _____

Name (Last) _____ (First) _____ (MI) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Mobile _____

Social Security No. _____ DOB _____

Driver's License No. _____ MVR Result _____

•Have you ever applied to our company before? Yes No
If yes, when? _____

•Have you ever been employed by us? Yes No
If yes, when? _____

•If you are under 18 years of age, can you provide the required proof of your eligibility to work? Yes No

•Are you currently employed? Yes No

•May we contact your present employer? Yes No

•On what date will you be able to work? _____

•Are you available to work: Full Time Part Time Shift Work Seasonal

• Are you currently on "lay-off" status and subject to recall? Yes No

•Have you been convicted of a felony in the last seven years? (Conviction will not necessarily disqualify an applicant from employment.) Yes No

•If yes, please explain. _____

• Are you a U.S. citizen? Yes No

•If no, do you have any documentation to prove that you are legally eligible to work in the United States? (Proof of citizenship or immigration status will be required upon employment.) Yes No

•List any friends or relatives who work here. _____

EDUCATION

	Name and Location of School	Years Attended	Date Graduated	Degree or Diploma Earned
High School				
College				
Graduate				
Other				

WORK EXPERIENCE

Employer		Starting Position		Starting Salary	
Street Address		Final Position		Final Salary	
City, State		Job Duties			
Phone Number		Supervisor/ Title			
Dates of Employment	Start: Month	Year	End: Month	Year	
Reason For Leaving					

Employer		Starting Position		Starting Salary	
Street Address		Final Position		Final Salary	
City, State		Job Duties			
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Employer		Starting Position		Starting Salary	
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City, State		Job Duties			
Phone Number		Supervisor/ Title			
Dates of Employment	Start: Month	Year	End: Month	Year	
Reason For Leaving					

• Describe any specialized training, apprenticeship, or skill: _____

• Please list any additional job skills that you believe would be relevant to the position for which you are applying. _____

APPLICANT'S STATEMENT

I certify that the information I have provided herein is true and complete to the best of my knowledge. If I become employed by this organization, I agree that any false statement, misrepresentation, or omission may result in my immediate termination.

I hereby authorize Armour Tight Gunite, LLC and/or any of their authorized agents to gather information regarding the following: All records including criminal, credit, driving, and/or education, written or verbal information from previous employers, and any other pertinent information relating to the function of the job for which I am applying.

I understand that all inquiries on this form are used for identification purposes only in order to conduct a background check, and are asked for legitimate nondiscriminatory reasons. Responses to sex, age, and race inquiries are voluntary, and choosing not to respond will preclude hire or promotion. I hereby release former employers, other references, and Armour Tight Gunite, LLC and any of its authorized agents from liability and understand there is no invasion of privacy.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law that my employment is at will. This means I do not have a contract of employment for any particular duration or that limits the grounds for termination in any way. I am free to resign at any time. Similarly, Armour Tight Gunite, LLC is free to terminate my employment at any time for any or no reason. It is further understood that my "at will" employment may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

I understand that I am required to abide by all rules and regulations of the employer.

Name of Applicant _____ Date _____

Signature of Applicant _____

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

**ACKNOWLEDGMENT AND RELEASE
FOR
ALCOHOL/DRUG/SUBSTANCE ABUSE POLICY
AND TESTING PROGRAM**

I _____ have been told and understand that my employer has a policy
(Employee's Name)
that employees under the influence of alcohol or chemical substances during working hours may be
immediately discharged.

I agree that under appropriate circumstances, particularly if I am involved in an accident during working hours,
I will be required and will submit to a test administered by a qualified authority that will determine if alcohol or
chemical substances are present. I understand that positive results of this test can affect my eligibility for
workers' compensation benefits. (Florida Statute 440.09(3))

I further understand that employment and continued employment depends upon my agreement to submit at any
time and without prior notice to a drug/alcohol screen. I further understand that refusal to submit voluntarily to
such tests or the detection of the presence of alcohol or drugs by such a test will result in my immediate
discharge.

This policy has been read by me and I fully understand it.

I do hereby authorize my employer to obtain medical records, or tests, which indicate the presence of alcohol or
chemical substances in my body.

I also agree that Photostat and/or faxed copies of this authorization be accepted if necessary.

Date: _____ Applicant Signature: _____

ACKNOWLEDGEMENT OF MANAGED CARE PROGRAM

I understand that my employer's workers' compensation insurance has a Managed Care Program and all work
related injuries will be tested according to that program.

Date: _____ Applicant Signature: _____

Date: _____ Witness Signature: _____

Form W-4 (2007)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax

for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners/Multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent. **A** _____

B Enter "1" if:
 • You are single and have only one job; or
 • You are married, have only one job, and your spouse does not work; or
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less, **B** _____

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) **E** _____

F Enter "1" if you have at least \$1,500 of child or dependent care expenses for which you plan to claim a credit **F** _____

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub 972, Child Tax Credit, for more information.
 • If your total income will be less than \$57,000 (\$85,000 if married), enter "2" for each eligible child.
 • If your total income will be between \$57,000 and \$84,000 (\$85,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have 4 or more eligible children. **G** _____

H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ► **H** _____

For accuracy, complete all worksheets that apply.
 • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
 • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4		Employee's Withholding Allowance Certificate		OMB No. 1545-0074
Department of the Treasury Internal Revenue Service		► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		2007
1 Type or print your first name and middle initial.		Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withheld at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		6 Additional amount, if any, you want withheld from each paycheck		5 6 \$
7 I claim exemption from withholding for 2007, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ► 7				
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (Form is not valid unless you sign it.) ►		Date ►		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)	10 Employer identification number (EIN)	

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE. It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.		I attest, under penalty of perjury, that I am (check one of the following):	
		<input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A Lawful Permanent Resident (Alien #) _____ <input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____	
Employee's Signature			Date (month/day/year)

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	
		Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.	
Document Title: _____	Document #: _____
Expiration Date (if any): _____	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
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Health Questionnaire

This questionnaire is not being used as the basis for deciding whether to employ you. It is solely for the purpose of providing information to the Florida Special Disability Trust Fund in appropriate cases.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip _____ Code: _____

Social _____ Security _____ Number: _____
Sex: _____

Date _____ of _____ Birth: _____
Weight: _____ Height: _____

Do you have or have you ever had any of the following? You must answer all questions. Any yes answer must be fully explained below.

	YES	NO		YES	NO
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac (heart) Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Marie Strum Pell Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Virus	<input type="checkbox"/>	<input type="checkbox"/>
Any Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Osteomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Joints	<input type="checkbox"/>	<input type="checkbox"/>
Any Amputation	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Thrompophlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Herniated Intervertebral Disc	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Circulation Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Back Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric or Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Skin Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Treatment or Evaluation	<input type="checkbox"/>	<input type="checkbox"/>

Health Questionnaire – Continued Page 2

Have you ever received treatment for a back, neck or knee condition, or a head injury? _____

Do you now or have you ever suffered from aches or pains of the back? _____

Have you ever had any surgery?

Do you now or have you ever had any physical disabilities, impairments, or handicaps?

Have you ever had a workers' compensation injury?

Have you ever received compensation or medical benefits under worker's compensation?

Are there any questions you do not understand? If yes, which question(s)?

Explain in detail any **YES** answers. _____

I understand and agree that if I am injured on the job, regardless of how minor, I am to report the injury immediately to my supervisor.

I further understand and agree that my employer's workers' compensation carrier will determine the medical facility and/or doctors I am to use.

I certify the above answers to be true and correct. I understand that any false or misleading answers to these questions will be sufficient reason for denial of benefits under the Florida Workers' Compensation Act, and will be the basis for termination.

Date: _____ **Applicant's Signature:**
