City of Hazlehurst

APPLICATION FOR EMPLOYMENT
(NOT FOR USE IN POLICE DEPARTMENT EMPLOYMENT)

The City of Hazlehurst provides equal opportunity in all areas of employment and does not discriminate against any individual regardless of race, color, religion, sex, national origin, age, marital, sexual orientation or veteran status, disability, or any other legally protected status.

Date:_____ SSN:_____ DOB:_____

Name:_____
First Middle Last

Present Address:_____
Street City State Zip Code

Telephone:_____ Alternate Number:_____

In case of emergency contact:_____
Name Relationship

_____
Address City State Zip Code

Position Applying For:_____

Who Referred you to us:_____

Are you related to anyone employed with the City of Hazlehurst: Yes No

If yes, give name(s) and relationship:_____

Are you a citizen of the United States: Yes No

If no, are you authorized to work in the United States? Yes No

Have you ever worked for the City of Hazlehurst? Yes/No If so, when?_____

Please provide an email address:_____

Education:
High School:_____ Graduated:_____
College:_____ Graduated:_____
Technical School:_____ Study:_____

Employment History:
Present/Most Recent Employer:_____
Address:_____ Supervisor's Name_____
Start Wages:_____ End Wages:_____ Begin Date:_____ End Date:_____
Reason for Leaving:_____
May we contact your previous employer? Yes No

Recent Employer:_____
Address:_____ Supervisor's Name_____
Start Wages:_____ End Wages:_____ Begin Date:_____ End Date:_____
Reason for leaving:_____
May we contact your previous employer: Yes No

Military Experience:
Branch of Service:_____ Final Rank:_____
Date Entered:_____ Date of Discharge:_____
Type of Discharge:_____ Status:_____
Schools/Special Training:_____
Reserve/National Guard Status:_____ Selective Service Class:_____

(List three (3) references who are not related or previous employers)
Name:_____ Telephone:_____ Yrs. Known_____

Name:_____ Telephone:_____ Yrs. Known_____

Name:_____ Telephone:_____ Yrs. Known_____

AT-WILL EMPLOYMENT

All employment and compensation with the City of Hazlehurst is "at will" and can be terminated with or without cause, and with or without notice, at any time, at the option of either the City of Hazlehurst or yourself, except as otherwise provided by law.

Disclaimer and Signature:(MUST BE SIGNED IN PRESENCE OF NOTARY)
I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release or termination.
Signature:_____ Date:_____

Notary Public:_____ Expires:_____

MUST PRESENT VALID DRIVERS LICENSE OR PROOF OF I.D. FOR EMPLOYMENT

DRUG-FREE WORKPLACE
All employees are subject to drug and alcohol testing
procedures permitted under federal and state law.

City of Hazlehurst

city.clerk@hazlehurstga.gov

86 S. Cromartie Street – Post Office Box 519
Hazlehurst, Georgia 31539-0519

Phone Number (912) 375-6680
Fax Number (912) 375-6690

STATEMENT OF AUTHORIZATION TO OBTAIN VEHICLE DRIVER'S RECORD

THE UNDERSIGNED DOES HEREBY ACKNOWLEDGE AND CERTIFY AS FOLLOWS:

1. Certifies that the undersigned is an employee or has applied to become an employee of the below named employer in a position which involves the operation of a motor vehicle and the undersigned gives his or her consent to the release of their driving record (MVR) for review by The City of Hazlehurst.
2. That the undersigned authorizes his or her driving record to be periodically obtained and reviewed for the purpose of initial and continued employment.
3. That all information presented in this form is true and correct. The undersigned makes this certification and affirmation under penalty of perjury and understands that knowingly making a false statement or representation on this form is a criminal violation.

Applicant's Name(Print)_____DOB_____
Print name as it appears on driver's license

License Number_____Expiration Date:_____State of _____

Signature of Applicant_____ Date_____

Employer Authorized Representative Name:_____

Signature of Authorized Representative:_____ Date:_____

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AUTHORITY FOR RELEASE OF INFORMATION

I hereby authorize any investigators or duly accredited representative of the City of Hazlehurst bearing this release, or a copy thereof, within one year of its date, to obtain any information from schools, residential management agents, employers, criminal justice agencies, of individuals, relating to my activities. This information may include, but is not limited to, academic, residential, achievement, performance, attendance, personal history, disciplinary, arrest, and conviction records. I hereby direct you to release such information upon request of the bearer. I understand that the information release is for official use by the City of Hazlehurst and may be disclosed to such third parties as necessary in the fulfillment of official responsibilities.

I hereby release any individual, including record custodians, from any and all liability for damages of whatever kind or nature which may be at any time result to me on account of compliance, or any attempts to comply with this authorization. Should there be any questions as to the validity of this release, you may contact me as indicated below.

Signature (full name) _____

Print Full Name_____

Other names or Aliases Used_____

Date of Birth_____

Current Address_____

Telephone Number (including area code)_____

Social Security Number_____

Today's Date_____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.) _____
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

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JOB DESCRIPTION/ESSENTIAL FUNCTIONS

JOB TITLE/DESCRIPTON_____

Once a conditional job offer is made, please be aware all persons may be required to furnish health condition information and, if necessary, submit to an examination by a company-designed physician. This information will be used to determine appropriate job placement. It shall not be used to disqualify as otherwise qualified person who may have mental or physical disability.

The following are physical requirements pertaining to the job for which you are applying. These physical requirements are essential functions of the job and are in addition to the skills, certifications, and years of experience or other qualifications required to perform the job(s) for which you have applied.

NOTE: Only those essential functions relevant to the job(s) for which you have applied will be checked below. Are you able to perform the tasks or functions that are checked(√).

Are you physically able to type or work at a keyboard or computer most of the day, if required?.....Yes No

Work at and view a video display terminal for an eight hour or more shift?.....Yes No

Grip, grasp, and twist using your hands and wrists?.....Yes No

Stand for long periods of time during your shift?.....Yes No

Lift and/or carry up to 25 lbs. regularly during your shift? ..... Yes No

Reach over your head with 10 – 25 lb. loads regularly during your shift, if required?.....Yes No

Work around dust and wear a respirator, if required? ..... Yes No

Wear proper safety equipment-hardhat, goggles, gloves, steel toe boots, etc?..... Yes No

Understand hazard communications and safety information?..... Yes No

Other/additional essential functions?..... Yes No

Based on the information discussed and/or received, I feel as though I CAN/CANNOT perform the essential functions of the job we've discussed.

*If you cannot perform one or more of the job requirements noted above, and you feel we can modify any part of the job and/or schedule to enable you to do the work, please explain in the space below:_____.

*Job modifications will be addressed on a case-by-case basis.

I have reviewed a summary or had explained to me the functions of the job noted on this page. (Due to various functions of most jobs, a comprehensive description of all duties to be performed is not possible.) The company reserves the right to assign duties not previously described or explained. Should you have reason why you are unable to perform a certain job function, it is your responsibility to report it to your supervisor. The company reserves the right to modify job descriptions in the future, with or without notice to the individuals affected by the job modifications.

IF THERE IS ANY QUESTION OR STATEMENT THAT YOU DO NOT UNDERSTAND, ASK FOR ASSISTANCE FROM THE PERSON INTERVIEWING YOU

My above statements are true to the best of my knowledge and I understand that any false statements or omissions will make me subject to discharge.

Signature_____Print Name_____Date_____

Company Representative_____ Date_____

POST-JOB OFFER MEDICAL QUESTIONNAIRE

Applicant/Employee Name_____

Social Security Number_____-_____-_____ DOB_____

NOTICE: This medical history statement is required of all persons offered a job. We are an Equal Opportunity Employer and the information requested below shall not be used for any unlawful purpose with respect to hire, tenure, terms, conditions or privileges of employment, or any matter directly related to employment, as prohibited by applicable local, state or federal law. Reasonable accommodation will be made if appropriate, provided it does not pose an undue hardship upon the company making the conditional job offer.

Height_____ft._____in. Weight_____

Have you ever been injured?	Yes/No_____
Have you ever been seriously ill?	Yes/No_____
Have you ever been hospitalized/confined to a hospital?	Yes/No_____
Have you ever been confined to a sanitarium?	Yes/No_____
Have you ever had an operation?	Yes/No_____
Have you ever broken a bone?	Yes/No_____
Have you ever been treated for alcoholism, drug habit,	Yes/No_____
Nervousness, or mental condition?	Yes/No_____
Do you need to wear glasses?	Yes/No_____
Do you need to wear a hearing aid?	Yes/No_____
Do you have a service connected disability?	Yes/No_____
Do you have any deformities/or disabilities?	Yes/No_____
For Women: Are you pregnant?	Yes/No_____
For Women: Is menstruation regular/normal?	Yes/No_____

Immunizations: Smallpox_____ Typhoid_____ Tetnus_____

Have you ever suffered from, or were you ever told that you had any of the following, please check:

_____heart trouble or blood diseases	_____rheumatism	_____fainting spells/dizziness
_____high blood pressure	_____back trouble/injury	_____head injury
_____shoulder injury	_____neck injury	_____arm injury
_____knee injury	_____neck surgery	_____back surgery
_____carpal tunnel syndrome	_____cubital tunnel syndrome	_____headaches/dizziness
_____low blood pressure	_____rheumatic fever	_____heat cramps
_____mental disorder	_____epilepsy fits/convulsions	_____allergenic conditions
_____cancer	_____poliomyelitis	_____nervous disorder
_____tuberculosis	_____prolonged fever	_____skin disease
_____kidney/bladder trouble	_____asthma/hay fever	_____venereal disease
_____hernia/rupture	_____persistent cough	_____hemorrhoids
_____arthritis	_____far/eye disease	_____diabetes
_____cerebral palsy	_____multiple sclerosis	_____Parkinson's disease

If you answered "Yes" to any of the above in question one, then for each please:

a. Identify what the specific injury or condition was and how it occurred:

_____

_____

_____

b. State whether the condition or injury resulted in surgery and if so what type of surgery was performed and list the impairment rating given from the physicians(if applicable):

_____

_____

_____

c. State whether you have physician imposed physical restrictions OR personally imposed physical restrictions as a result of the injury or condition and what those restrictions are:

_____

_____

_____

Do you or did you have any disability or physical or mental condition which limits you in anyway? Yes No
If yes, please explain:_____

_____

_____

Have you ever had an accident or suffered an injury, illness or disease while on the job for any employer or while in the course of any self-employment? Yes No

Who was the employer?_____
What was the injury, illness, disability or disease?_____
Did you miss work?_____
Did you receive Worker's Compensation benefits?_____
Name & Address of the doctor who treated you_____

Have you ever been turned down for any employment, medical, health or life insurance or military service because of your health or physical or mental condition? Yes No
If yes, please explain:_____

_____

_____

Are you currently taking any medications? _____Yes _____No If "Yes", explain:

_____

For what condition(s) was the medication(s) prescribed?

_____

I hereby affirm that the answers to this post-job offer medical questionnaire are truthful.

Signature_____ Date_____

This form must be signed and dated for completion.

Name-Based Criminal History Record Information (CHRI) Consent/Inquiry Form

I hereby authorize Hazlehurst Police Department to conduct an inquiry for
Agency/Company
the purpose below and receive any Georgia and/or national CHRI as authorized by state and federal law.

Full Name (print)			
Address			
Sex	Race	Date of Birth	Social Security Number

☐ This authorization is valid for _____ days from date of signature.

☐ I, _____, give consent to the above-named entity to perform periodic criminal history background checks for the duration of my employment.

_____ _____
Signature Date

_____ _____ _____
Attorney for Individual (Purpose Code E and U Only) Bar Number Date

Date of Inquiry: _____ Time of Inquiry: _____ Operator's Initials: _____

Purpose Code Used (check one): Note: *Only one inquiry may be performed per consent form.*

NON-CRIMINAL JUSTICE PURPOSES		
	E	Employment
	M	Employment direct care with Mentally Ill/Developmentally Disabled
	N	Employment direct care with Elderly
	W	Employment direct care with Children
	P	Public Record (no consent required)
	F	Probate Court/Weapons Carry License
PERSONAL REQUEST (INDIVIDUAL OR THEIR ATTORNEY)		
	U	Personal Copy (stamp return "personal copy")
CRIMINAL JUSTICE EMPLOYMENT		
	J	Civilian Criminal Justice Employment (state and III data received)
	Z	Sworn Criminal Justice Employment (state and III data received)

This inquiry resulted in the following (check all that apply):

	No criminal history available
	Criminal history available (attached/released)
	No NCIC/GCIC Warrant
	Possible NCIC/GCIC Warrant (list Wanting agency below)
	Wanting Agency Name:
	Wanting Agency Telephone:

Agency Designee Signature and Title