R.B.T. WELDERS, LLC

PLEASE PRINT CLEARLY

APPLICATION FOR EMPLOYMENT

NAME	FIRST	MIDDLE	LAST	NICKNAME	SOCIAL SECURITY NO. / /
ADDRESS	NUMBER STREET	CITY	STATE	ZIP CODE	TELEPHONE (.)
MARITAL STATUS CIRCLE ONE	SINGLE MARRIED DIVORCED	SPOUSES NAME		EMERGENCY CONTACT NAME	PHONE NUMBER ( )

POSITION(S) APPLIED FOR

1ST CHOICE _____ RATE OF PAY EXPECTED $_____ / YRS. EXP._____

2ND CHOICE _____ RATE OF PAY EXPECTED $_____ / YRS. EXP._____

PREVIOUS EMPLOYMENT

List below all present and past employment beginning with your most recent.

EMPLOYER	DATES EMPLOYED	JOB TITLE	RATE OF PAY	REASON FOR LEAVING
NAME	FROM			
ADDRESS	TO			
NAME	FROM			
ADDRESS	TO			
NAME	FROM			
ADDRESS	TO			
NAME	FROM			
ADDRESS	TO			

_____

SIGNATURE OF APPLICANT

_____

DATE

FOR OFFICE USE ONLY:

RATE OF PAY _____

JOB TITLE _____

DATE _____

NOTICE TO ALL EMPLOYEES

We are committed to providing Worker's Compensation benefits to all employees who sustain related injury in accordance with Louisiana law.

If a work related injury or disability is caused or made worse by a "pre-existing" Condition, R.B.T. Welder's LLC may be able to seek partial reimbursement of the Benefit dollars paid to you, or on your behalf, from the Louisiana Second Injury Fund. Such reimbursement would be made to R.B.T. Welder's LLC without reduction in benefits to you.

In order for R.B.T. Welder's LLC to be considered for reimbursement from the SECOND INJURY FUND, it has to show that it knowingly hired or knowingly retained the employee with a pre-existing disability. To establish this act, R.B.T. Welder's LLC requires all employees to complete the attached questionnaire.

The information obtained from the questionnaire will be kept CONFIDENTIAL and will not be a part of the employee's personnel file. As you complete the attached Questionnaire, you should be aware that:

FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN
FOREFITURE OF YOUR WORKER'S COMPENSATION
BENEFITS UNDER LA R.S.23; 1208.1.

I understand that there is a required pre employment drug screen, and I may be subjected to random drug screening during my employment. I also understand that if found positive I will be terminated.

I have read the foregoing notice and have completed the attached questionnaire to the best of my knowledge, information, and belief.

All applicants must be able to speak and understand the English language for instructions and safety.

I certify that I understand oral and written communication in the English Language.

_____

EMPLOYEE

_____

DATE

EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE FOR SECOND INJURY FUND PURPOSES

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO

1. Have you ever had a disease or disability arising from your occupation? YES NO
   If YES, please explain:

_____

_____

_____

2. Have you ever received workers' compensation benefits for an injury that occurred at work? YES NO
   If YES, when? _____
   How long were you on compensation? _____
   Name of Employer: _____
   Name of Injury: _____

3. Have you ever been rejected for employment, insurance, or military service because of health? YES NO
   If YES, please explain:

_____

_____

4. Have you ever had back trouble or injury to your back, head or neck? YES NO
   If YES, please explain:

_____

_____

5. Do you have any restrictions or limitations upon your physical activities? YES NO
   If yes, please explain:

_____

_____

6. What operations, accidents, broken bones, strains or serious illnesses have you had?

_____

_____

Have you had any of the following? Put a (X) for YES and leave it blank for NO

- ☐ Amputation (foot, leg, arm, hand or total loss of use thereof)
- ☐ Ankylosis of Joints
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back/Neck Problem
- ☐ Brain Damage
- ☐ Cancer
- ☐ Cardiac Disease
- ☐ Cerebral Palsy
- ☐ Cerebral Vascular Accident
- ☐ Chronic Headaches
- ☐ Chronic Osteomyelitis
- ☐ Communicable Disease
- ☐ Compressed Air Sequelae
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Condition
- ☐ Heavy Metal Poisoning
- ☐ Hemophilia
- ☐ High/Low Blood Pressure
- ☐ Hodgkin's Disease
- ☐ Hyperinsulinism
- ☐ Kidney Disorder
- ☐ Loss of Sight (of one or both eyes a partial loss of uncorrected vision of more than seventy-five percent)
- ☐ Loss of Use of Limbs
- ☐ Mental Disorders
- ☐ Mental Retardation
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Nervous Disorders
- ☐ Numbness of Extremities
- ☐ Parkinson's Disease
- ☐ Psychoneurotic Disability (following treatment in a recognized medical or mental institution)
- ☐ Repetitive Motion Injury
- ☐ Residual Disability from Polio
- ☐ Rheumatism
- ☐ Ruptured Intervertebral Disc
- ☐ Silicosis
- ☐ Spinal Fusion
- ☐ Stroke
- ☐ Sugar in Urine
- ☐ Surgical Removal of Intervertebral Disc
- ☐ Thrombophlebitis
- ☐ Thyroid Condition
- ☐ "Trick" Knee or Shoulder
- ☐ Tuberculosis
- ☐ Varicose Veins
- ☐ Ionizing Radiation Injury

If YES, please explain: _____

_____

_____

7. Do you have any other long-term health problems or adverse physical conditions? YES NO

If YES, please explain: _____

_____

_____

Signature: _____ Date: _____

Name Printed: _____