

"Oilfield Production Contractors, Inc."

" Safety First "

" Application For Employment "

Date of Application: _____ (Please Print Clearly and Read all Statements Completely)

TO APPLICANT: You must personally complete the application for it to be considered. Applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, or disability.

Referral Source: Name of Employee Referral _____ Walk-In
 Advertisement Other _____

Name _____
 First Middle Last

Address _____
 Number Street City State Zip Code

Telephone () _____ - _____ Social Security Number _____ - _____

Other telephone numbers (example cell phone, pager, Moms house, etc.) _____

Are you presently employed? Yes No May your present employer be contacted? Yes No

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status? Yes No

Do you have dependable transportation? Yes No Have you ever been convicted of a felony? Yes No

Can you swim? Yes No

Position Applied For: Lease Operator Helper Lease Operator Technician Instrumentation Other _____

Education: Grade School High School College Trade School Other _____

Are you capable & qualified to perform personnel transfer by rope and/or personnel transfer basket. Yes No

Have you had a physical Examination in the Past 5 years? Yes No Will you be willing to take a Physical Examination if Required? Yes No

To your knowledge do you have or have you ever had any of the following Ailments? (Check Yes or No)

Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Rupture	<input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Heart Disease
<input type="checkbox"/> <input type="checkbox"/> Defective Sight	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Defective Hearing	<input type="checkbox"/> <input type="checkbox"/> Silicosis or Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Rheumatism or Arthritis	<input type="checkbox"/> <input type="checkbox"/> Back Trouble	<input type="checkbox"/> <input type="checkbox"/> Loss of any organ	<input type="checkbox"/> <input type="checkbox"/> Cancer of any type

Do you have any physical or mental condition (s) other than those identified above which would interfere with or hinder the performance of this job for which you wish to be considered? If so, please explain: _____

Have you ever had an on the job injury? Yes No (If answer is Yes complete below)

Approximate Date of Injury	Employer at Time of Injury	Nature of Injury	Were you Disabled?	Approximate Length of time you were off work	Was a claim for benefits made?
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Will you abide by the Safety rules of this company? Yes No If injured will you accept the medical facilities recommended by your employer? Yes No

Have you ever been convicted of a criminal offense (do not include parking tickets)? Yes No (Conviction is not an automatic bar to employment)

If Yes	Date	Nature of Conviction	Where	Disposition of offense