

**"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)

Have you ever received workman compensation benefits?  Yes  No

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