Job Application

Central Iowa Dirt Works
5158 NW Beaver Drive
Johnston, IA 50131
Phone: 515-208-7566
Email: cody@centraliadirtworks.com

Personal Information

Last	First	MI	SSN#	Email	
Street Address	City	ST	Zip	Home Phone	Mobile Phone

Are you entitled to work in the United States?	Are you 18 or older?	If yes, Date of Birth
Have you been convicted of a felony or been incarcerated in connection with a felony in the past seven years?	If yes, please explain:	
Military Service? Branch	Are you a veteran? War	
What position are you applying for?	How did you hear about this position?	
Expected Hourly Rate / Expected Weekly Earnings	Date Available	

Prior Work Experience

	Current or Most Recent	Prior	Prior
Employer			
Address			
City, ST, ZIP			
Telephone			
Name of Immediate Supervisor			
Dates of Employment	From To	From To	From To
Position/Job Title			
Pay			
Reason for Leaving			
May We Contact			

Education

	Name/Location	Last Year Complete	Degree	Major or Emphasis
High School		9 10 11 12		
College/University		1 2 3 4		
Trade School				
Other				
List any applicable special skills, training or proficiencies.				

Disclaimer - By signing, I hereby certify that the above information, to the best of my knowledge, is correct. I understand that falsification of this information may prevent me from being hired or lead to my dismissal if hired. I also provide consent for former employers to be contacted regarding work records.	Signature	Date

Friedman Insurance, Inc.

In accordance with the Fair Credit Reporting Act (FCRA), the below listed applicant has authorized Friedman Insurance Inc. to obtain a Motor Vehicle Record (MVR) for purposes of obtaining insurance.

Applicant's Name:

_____
Last, First, Middle Initial (Please Print)

_____
License Number

_____
State

_____
Date of Birth

_____
Signature

_____
Date

HealthCARE Express™
Urgent Care & Occupational Medicine
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Physical Evaluation

Name: _____ **Sex:** _____ **Age:** _____ **Date of Birth:** ____/____/____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Personal/Family Physician: _____ **City/State:** _____ **Phone:** _____

Medical History (Explain "yes" answers below. Circle questions you do not know the answer to.)

1. Have you had a medical illness or injury in the last 5 years?	**Yes**	**No**	**17. Have you ever had a head injury or concussion?**	**Yes**	**No**
2. Do you have problems with your eyes, ears, nose or throat?	Yes	No	18. Have you ever had a seizure?	Yes	No
3. Do you wear corrective lenses?	**Yes**	**No**	**19. Do you have frequent or severe headaches?**	**Yes**	**No**
4. Do you have an ongoing chronic illness?	Yes	No	20. Have you ever been knocked out, become unconscious or lost your memory?	Yes	No
5. Have you ever been hospitalized overnight?	**Yes**	**No**	**21. Have you had any problems with your eyes or vision?**	**Yes**	**No**
6. Have you ever had surgery?	Yes	No	22. Do you wear glasses, contacts or protective eyewear?	Yes	No
7. Are you currently taking any prescription or non-prescription (over-the counter) medications?	**Yes**	**No**	**23. Have you ever had a sprain, strain or swelling after injury?**	**Yes**	**No**
8. Do you have any allergies (i.e. pollen, medicine, food, animals, or stinging insects)?	Yes	No	24. Have you broken or fractured any bones or dislocated any joints?	Yes	No
9. Do you have seasonal allergies that require medical treatment?	**Yes**	**No**	**25. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?**	**Yes**	**No**
10. Do you have asthma?	Yes	No			
11. Do you cough, wheeze or have trouble breathing during or after activity?	**Yes**	**No**	26. Have you ever had sleep disorders (i.e. pauses in breathing while asleep, daytime sleepiness, loud snoring)?	**Yes**	**No**
12. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus or blisters)?	Yes	No			
13. Have you ever had racing of your heart or skipped heartbeats?	**Yes**	**No**	**27. Have you ever had diabetes or elevated blood sugar?**	**Yes**	**No**
14. Have you had high blood pressure or high cholesterol?	Yes	No	28. Have you ever had numbness or tingling in your arms, hands, legs or feet?	Yes	No
15. Have you ever been told you have a heart murmur?	**Yes**	**No**	**29. Do you frequently consume alcohol?**	**Yes**	**No**
16. Has any family member or relative died of heart problems or sudden death before age 50?	Yes	No	30. Do you use narcotic or habit forming drugs?	Yes	No

Explain "Yes" answers here:

_____

_____

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Physical Examination

Name: _____ **Date of Birth:** ____/____/____

Height: _____ **Weight:** _____ **% Body Fat:** _____ **Pulse:** _____

Blood Pressure: _____/_____ (_____/_____ , _____/_____)

Visual Acuity: **Right 20/**_____ **Left 20/** _____ **Corrected: Yes | No** **Pupils:** **Equal** _____ **Unequal** _____

FINDINGS	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

_____ **Cleared without limitation**

_____ **Not cleared for:** _____

Reason: _____

_____ **Cleared after completing evaluation/rehabilitation for:** _____

_____ **Referred to:** _____

For: _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ **Date:** ____/____/____

Address: ____ 3515 Richmond Road, Texarkana, TX 75503 ____ 4701 W. 7th Street, Texarkana, TX 75501 ___ 1509 W. Loop 281, Longview, TX 75605

Signature of Physician/Physician Assistant/Nurse Practitioner _____