St. Landry Parish Government
P.O. Drawer 1550
Opelousas, LA 70571-1550
Telephone: (337)948-3688
Fax: (337)948-1281
www.stlandryparishgovernment.org

Company Policy

In an effort to promote and maintain a safe, healthful, productive and efficient environment and work place, St. Landry Parish Government and its entire subsidiary, adopts a policy against drug abuse. It places in effect a testing program administered by Drug Testing Consortium and/or which conforms to all requirements issued by the United States Department of Transportation as outline in 49CFR Part 40. A copy of the entire plan is available to all employees to read by contacting the Safety Department.

To accomplish this purpose, St. Landry Parish Government does hereby prohibit the possession, use, distribution or sale of illegal drugs on St. Landry Parish premises and all locations by employees. Any employee reporting for work in a condition caused by off-duty use of drugs, alcohol or controlled substances, which detrimentally affect his or her ability to perform work, shall be deemed in violation of St. Landry Parish Government's policy and subject to disciplinary action set forth below:

CONSEQUENCES OF POSITIVE TEST RESULTS

A. APPLICANTS: Job applicants will be denied employment with St. Landry Parish Government and all its subsidiaries, if their test results are positive on a pre-employment drug test.
B. EMPLOYEES: If an employee's test results are positive, on random, post accident, or reasonable cause drug and/or alcohol test, the employee is subject to disciplinary action up to and including termination of employment.

All employees testing positive in the above circumstances will be permitted to go through a rehabilitation program at his or her expense. If the employee refuses to attend rehabilitation or does not successfully complete such a program, they will be terminated.

After successfully completing such a program, a copy of completion must be submitted to Dr. Brian Heinen, Medical Review Officer. At such time, Dr. Heinen will direct Drug Testing Consortium to perform a mandatory back to duty test. Negative results are needed prior to employee returning to work. The employee will further be subjected to mandatory testing for a period of two (2) years.

ALL SECOND OFFENDERS WILL BE TERMINATED

St. Landry Parish Government has contracted with Drug Testing Consortium to perform all of its drug and alcohol testing, provide employee assistance program, medical review officer, and plan book which must conform to DOT Regulation 49CFR Part 40.

_____ _____

EMPLOYEE SIGNATURE COMPANY REPRESENTATIVE

EMPLOYEE INFORMATION

(Please Print)

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

SOCIAL SECURITY NUMBER: _____

DRIVER'S LICENSE NUMBER: _____

PHONE NUMBER: _____

CELL PHONE NUMBER: _____

EMERGENCY CONTACT INFORMATION

NAME: _____

PHONE NUMBER: _____

CELL PHONE NUMBER: _____

APPLICATION FOR EMPLOYMENT

We consider applicants for all position without regard to race, color, religion, sex, national origin, age, martial or veteran status, the presence of a non-job-related medical condition or handicap, or any other legally protected status.

(PLEASE PRINT)

DATE OF APPLICATION _____

POSITION(S) APPLIED FOR _____

HOW DID YOU LEARN ABOUT US?

☐ ADVERTISMENT ☐ FRIEND ☐ WALK-IN ☐ EMPLOYMENT AGNECY ☐ RELATIVE

☐ OTHER (explain)_____

_____

LAST NAME FIRST NAME MIDDLE NAME

_____

ADDRESS CITY STATE/ZIPCODE

_____

TELEPHONE NUMBER _____

SOCIAL SECURITY NUMBER _____

- If you are under 18 years of age, can you provide required proof of your eligibility to work?

☐ YES ☐ NO

- Have you ever filed an application with us before? ☐ YES ☐ NO

If yes, give date _____

- Have you ever been employed with us before? ☐ YES ☐ NO

If yes, give date _____

- Are you currently employed? ☐ YES ☐ NO

- May we contact your present employer? ☐ YES ☐ NO

- Are you prevented from lawfully becoming employed in this country because of Visa or immigration status? *(Proof of citizenship or immigration status will be required upon employment)*

☐ YES ☐ NO

- On what date would you be available for work? _____
- Are you available to work: ☐ Full time
  ☐ Part time
  ☐ Shift work
  ☐ Temporary
- Are you currently on "lay-off" status and subject to recall? ☐ YES ☐ NO
- Can you travel is a job requires it? ☐ YES ☐ NO
- Have you been convicted of a felony? ☐ YES ☐ NO

If yes, please explain _____

_____

_____

_____

EDUCATION

	Elementary School	High School	Undergraduate College/University	Graduate/ Professioinal
School Name & Location				
Years Completed				
Diploma/Degree				
Description of Course Study				
Describe any specialized training, apprenticeship, skills and extra-				
State any additional information you feel may be helpful to us in considering your application				
Indicate any foreign languages you can speak, read and/or write				
	FLUENT	GOOD	FAIR	
SPEAK				
READ				
WRITE				

List professional, trade, business or civic activities and offices held. *(You may exclude membership which would reveal sex, race, national origin, age, ancestry, or handicap or other protected status.)*

_____
_____
_____

REFERENCES

Give name, address and telephone number of three (3) references who are not related to you and are not previous employers.

1. _____
2. _____
3. _____

- Have you ever had any job-related training in the United States Military?

☐ YES ☐ NO

If yes, please describe _____

_____

- Are you physically or otherwise unable to perform the duties of the job for which you are applying? ☐ YES ☐ NO

EMPLOYMENT EXPERIENCE

Start with your present or last job. Include any job-related military service assignments and volunteer activities. (*You may exclude organization which indicates race, color, religion, gender, national origin, handicap or other protected status.)*

Employer	**Dates Employed**	Work Performed
Address	From	
Telephone Number(s)	To	
Job Title		
Supervisor	**Hourly Rate/Salary**	
Reason for Leaving	Starting	
	Final	

Employer	**Dates Employed**	Work Performed
Address	From	
Telephone Number(s)	To	
Job Title		
Supervisor	**Hourly Rate/Salary**	
Reason for Leaving	Starting	
	Final	

Employer	**Dates Employed**	Work Performed
Address	From	
Telephone Number(s)	To	
Job Title		
Supervisor	**Hourly Rate/Salary**	
Reason for Leaving	Starting	
	Final	

Employer	**Dates Employed**	Work Performed
Address	From	
Telephone Number(s)	To	
Job Title		
Supervisor	**Hourly Rate/Salary**	
Reason for Leaving	Starting	
	Final	

If you need additional space, please continue on a separate sheet of paper.

SPECIAL SKILLS AND QUALIFICATIONS

Summarize special job-related skills and qualifications acquired from employment or other experience.

_____

_____

_____

_____

ACKNOWLEDGEMENT

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at this time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "*at will*" nature, which means that the *employee* may resign at any time and the *employer* may discharge *employee* at any with or without cause. It is further understood that this "*at will*" employment relationship may be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

_____ _____

Signature of Applicant Date

FOR PERSONNEL DEPARTMENT USE ONLY

Arrange Interview ☐ YES ☐ NO

Remarks:_____

_____

_____

_____ _____

Interviewer Signature Date

Employed ☐ YES ☐ NO Date of Employment _____

Job Title _____

Hourly Rate/Salary _____

Department _____

By: _____ _____

Name and Title Date

Notes:_____

_____

_____

_____

This application for Employment and Employment Data Record is sold for general use throughout the United States. Amsterdam Printing and Litho Corp. assume no responsibility for the use of said form or any questions which, when asked by the employer of the job applicant may violate State and/or Federal Law.

Employees are treated during employment without regard to race, color, religion, sex, national origin, age, martial or veteran status, medical condition or handicap or any other legally protected status.

As an employer with an Affirmative Action Program, we comply with government record keeping, reporting, and other legal requirements. Periodic reports are made to the government on the following information. The completion completion of this data record is optional. If you choose to volunteer the requested information please note that all data records are kept in a Confidential File and <u>are not</u> a part of your Application for Employment or personnel file. Please note: YOUR COOPERATION IS VOLUNTARY. INCLUSION OR EXCLUSION OF ANY DATA WILL NOT AFFECT ANY EMPLOYMENT DECISION.

VOLUNTARY SURVEY

(Please Print)

Date _____

Government agencies at times require periodic reports of the sex, ethnicity, handicap, veteran and other protected status of employees. This data is for statistical analysis with respect to the success of the Affirmative Action program. SUBMISSION OF THIS INFORMATION IS VOLUNTARY.

NAME _____

ADDRESS_____

_____

SOCIAL SECURITY NUMBER _____

COMPLETE ONLY THE SECTIONS BELOW THAT HVE BEEN CHECKED

	CURRENT JOB
	CHECK ONE: ☐ MALE ☐ FEMALE
	CHECK ONE OF THE FOLLOWING: (Ethnic Origin) ☐ Caucasian ☐ Hispanic ☐ American Indian/Alaskan Native ☐ African American ☐ Other ☐ Asian/Pacific Islander
	CHECK ALL APPLICABLE: ☐ Vietnam Era Veteran ☐ Disabled Veteran ☐ Handicapped Individual
	BIRTH DATE:

LOUISIANA SECOND INJURY FUND QUESTIONNAIRE

NAME: _____ DEPARTMENT: _____

POSITION: _____

To the best of your knowledge do you have or have had any of the following medical problems? For responses indicate the nature of injury or illness and mane of physician in Remarks. Completion of this report requested is to assist your employer in the knowledge requirement of the Louisiana Second Injury Fund.

Answer YES (Y) or NO (N)

	EPILESPY		HYPERINSULISM (too much insulin)
	DIABETES		MUSCULAR DYSTROPHY
	CARDIC (HEART) DISEASE		ARTERIOSCLEROSIS (blockage or hardening of the arteries)
	ARTHRITIS – List body part(s) affected below		THROMBOPHLEBITIS (swelling of the veins)
	AMPUTATED foot, leg, hand or arm (or total loss of use thereof		VARICOSE VEINS
	LOSS OF SIGHT (of one or both eyes or partial loss of uncorrected vision of more than 75% bilaterally)		HEAVY METAL POISONING (such as lead, mercury, arsenic, etc.)
	RESIDUAL DISIBILITY FROM POLIOMYELITIS (Polio)		IONIZING RADIATION INJURY
	CEREBRAL PALSY		COMPRESSED AIR SEQUELAS (the bends)
	MULTIPLE SCLEROSIS (MS)		RUPTURED INTERVERTEBRAL DISC
	PARKINSON'S DISEASE		HODGKIN'S DISEASE (cancer of lymph glands)
	CEREBRAL VASCULAR ACCIDENT (Stroke or ruptured blood vessel in the head)		BRAIN DAMAGE
	TUBERCULOSIS		SPINAL FUSION (or the surgical removal of an intervertebral disc ((discectomy))
	SILICOSIS		MENTAL RETARDATION (provided the employee's intelligence quotient is such that he/she falls in the lowest 2% of the general population)
	PSYCHONEUROTIC (Mental) DISABILITY (following treatment in a recognized medical or mental institution)		Any other pre-existing disease condition or impairment which is permanent in nature
	HEMOPHILIA		Any workers compensation claims or automobile accidents (provide details below)
	CHRONIC OSTEOMYELITIS (infection of the bone or bone marrow)		
	ANKYLOSIS OF JOINTS (frozen joints)		

WARNING

PURSUANT TO LA R.S. 23:1208 AND 23:1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE ABOVE QUESTIONS MAY RESULT IN:

1. **FINES AND/OR IMPRISONMENT**
2. **A FORFITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT**

This form is to be used only in accordance with ADA guidelines.