

COMPANY STATEMENT

Each applicant is hereby advised that discrimination or harassment of any type will not be tolerated by DNP, INC. All employees may report any complaints or possible violations to either the manager of the jobsite at which they are employed, to the General Superintendent for the field in which they are employed, or to a member of the Personnel Department. DNP, INC. will promptly investigate and resolve all complaints with appropriate confidentiality.

DNP, INC. has a program of affirmative action. As part of this program, DNP, INC. will continue to emphasize to employees, potential employees, customers, vendors, and others that equal opportunities in DNP, INC. are based upon individual merit and will continue to encourage persons to seek employment and strive for advancement upon such a basis. Each manager, supervisor, and employee within the organization is charged with the enforcement of this policy and the implementation of these programs within his or her area of responsibility.

PLEASE READ CAREFULLY BEFORE SIGNING:

- I understand that completion of this application does not indicate that there are any positions open and does not in any way obligate DNP, INC.
- I agree, if employed, to abide by all of DNP, INC. rules, outlined in the New Employee Orientation and Information and General Standards of Conduct, copies of which are available from the Personnel Department.
- I authorize DNP, INC. to investigate all statements contained in this application. It is understood and agreed that any material misrepresentations by me in this application will be sufficient cause for disqualification of the application and/or for separation from DNP, INC. if I have been employed. I also authorize DNP, INC. to investigate my working ability and my character and reputation. I hereby release DNP, INC., its officers, representatives or agents and the person(s) DNP, INC. contacts in its investigation from any and all liability and/or damage incurred in obtaining or providing such information, and would be willing to sign releases to DNP, INC. to obtain personal reference information including background searches of military, criminal, credit, education and employment records.
- I understand DNP, INC.'s policy not to refuse to hire a qualified individual with a disability because of this person's need for an accommodation required by the ADA (Americans with Disabilities Act).
- EMPLOYMENT AT WILL. I understand that, if employed, I will be hired as an EMPLOYEE AT WILL and my continued employment is entirely subject to the discretion and best judgment of DNP, INC. and any information provided is not to be considered a contract between DNP, INC. and applicant. Further, I understand that any additional terms of employment must be expressly agreed to in writing.

I certify that the information given in this application is correct, and I acknowledge that I have read and understand DNP, INC.'s Equal Opportunity Employment Policy Statement and all others shown above:

DNP, INC. IS A DRUG FREE WORKPLACE: I understand and acknowledge that DNP, INC. has a drug testing policy which requires random testing during employment and on a for-cause basis of all employees. I hereby consent to undergo such testing, as required.

Date _____

Signature of Applicant _____

Signature of Witness _____

EQUAL OPPORTUNITY EMPLOYER

EDUCATION (Circle last year completed)

SCHOOL NAME

MAJOR SUBJECTS

YEAR

Elementary & Jr. High 5 6 7 8

High School 1 2 3 4

College 1 2 3 4

Graduate School 1 2 3 4

Other job-related education 1 2 3 4

Are you able to perform, with or without reasonable accommodation, the essential functions of the job or occupation for which you have applied? Yes No

OTHER JOB SKILLS/EQUIPMENT OPERATED

OTHER QUALIFICATIONS

WORK EXPERIENCE: Begin with present or most recent employer and account for all periods of time for the previous five years. Please fill out completely (Even if you provide a resume). **NOTE:** False information will automatically disqualify your application and may be cause for immediate termination. Attach additional pages if necessary.

1 Employer:

Address _____
City _____ State ____ Zip _____
Telephone _____
Position _____
Supervisor Name &
Title _____
Part Time or Full Time?

Dates Employed:
From _____ To _____
Starting Salary _____ Ending _____
Specific
Duties _____
Reason for Leaving?

2 Employer:

Address _____
City _____ State ____ Zip _____
Telephone _____
Position _____
Supervisor Name &
Title _____
Part Time or Full Time?

Dates Employed:
From _____ To _____
Starting Salary _____ Ending _____
Specific
Duties _____
Reason for Leaving?

3 Employer:

Address _____
City _____ State ____ Zip _____
Telephone _____
Position _____
Supervisor Name &
Title _____
Part Time or Full Time?

Dates Employed:
From _____ To _____
Starting Salary _____ Ending _____
Specific
Duties _____
Reason for Leaving?

4 Employer:

Address _____
City _____ State ____ Zip _____
Telephone _____
Position _____
Supervisor Name &
Title _____
Part Time or Full Time?

Dates Employed:
From _____ To _____
Starting Salary _____ Ending _____
Specific
Duties _____
Reason for Leaving?

VOLUNTARY AFFIRMATIVE ACTION INFORMATION

DATE: _____

NAME: _____

POSITION(S) APPLIED FOR: _____

REFERRAL SOURCES:

ADVERTISEMENT _____

EMPLOYEE _____

WALK-IN _____

GOVERNMENT EMPLOYMENT AGENCY _____

SCHOOL _____

RELATIVE _____

FRIEND _____

OTHER _____

As required, we comply with government regulations including Affirmative Action obligations, where they apply. In an effort to comply with government record keeping. Reporting and other legal obligations, we ask that you complete this applicant survey. Your cooperation is appreciated.

Please be advised that your survey is not an official application for employment. It is considered confidential information and will not be used in any hiring decisions.

CHECK ONE: MALE _____ FEMALE _____

CHECK ONE: HISPANIC _____ BLACK _____ CAUCASIAN _____
 AMERICAN INDIAN _____ OTHER _____

Special notice to Vietnam Era veterans, disabled veterans and individuals with physical or mental handicaps or disabilities:

Government contractors subject to the Vietnam war veterans readjustment act of 1974 and the rehabilitation Act of 1973 are required to take Affirmative Action to take Affirmative Action to employ and advance qualified disabled veterans of the Vietnam era and qualified handicapped individuals.

You are invited to volunteer this information, if you qualify, to assist in proper placement and determining reasonable accommodation. This information will be considered confidential and refusal to provide this information will not affect your consideration for employment.

If you wish to be identified, please check if any of the following are applicable.

Vietnam Era Veteran _____ Disabled Veteran _____
Handicapped Individual Other _____ Section 3/HUD _____

To be completed by applicant-not for interview purposes-to be filed separately from application. This information is used to satisfy the Affirmative Action requirements of section 503 of the Rehabilitation Act necessitated by another federal law or regulation.

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 05/31/2023

Name: _____
Employee ID: _____
(if applicable)

Date: _____

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

- Yes, I Have A Disability, Or Have A History/Record Of Having A Disability
- No, I Don't Have A Disability, Or A History/Record Of Having A Disability
- I Don't Wish To Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____