

PTAB Application for Safety Coordinator

Please answer all questions fully and accurately in your own handwriting.

| | | |
|--------------|------------------|----------------|
| Name _____ | Cell Phone _____ | |
| Street _____ | Home Phone _____ | |
| City _____ | State _____ | Zip Code _____ |
| Email _____ | | |

EDUCATION

| | |
|--|------------------------------|
| High School _____ | Graduated/GED?(yes/no) _____ |
| College _____ | Graduated?(yes/no) _____ |
| If yes, what degree(s) do you possess? _____ | |
| Certificate or Training Programs _____ | |

AVAILABILITY

| | |
|--------------------------------------|--------------------------|
| Dates Available: From _____ to _____ | Full-Time (yes/no) _____ |
|--------------------------------------|--------------------------|

WORK EXPERIENCE Start with your most recent experience. (If you are currently employed list that employer first.)

| | | | |
|--------------------------|-------------------------|--------------|----------|
| Employer _____ | Job Title _____ | Date: _____ | to _____ |
| Phone _____ | Supervisor's Name _____ | Salary _____ | |
| Duties _____ | | | |
| Reason for leaving _____ | | | |

| | | | |
|--------------------------|-------------------------|--------------|----------|
| Employer _____ | Job Title _____ | Date: _____ | to _____ |
| Phone _____ | Supervisor's Name _____ | Salary _____ | |
| Duties _____ | | | |
| Reason for leaving _____ | | | |

WORK EXPERIENCE (continued)

| | | | |
|-------------------------|------------------------|-------------|---------|
| Employer_____ | Job Title_____ | Date:_____ | to_____ |
| Phone_____ | Supervisor's Name_____ | Salary_____ | |
| Duties _____ | | | |
| _____ | | | |
| Reason for leaving_____ | | | |

***Write a paragraph summarizing your goals or ambitions:**

All PTAB employees are covered by Workers Compensation Insurance for work related injuries. PTAB's insurance carrier is The Zenith Insurance Company. In the event of any work related injury, which requires medical treatment, the injured employee is required to go to the designated medical provider posted at each inspection station or office site.

“At Will” Policy

I understand and agree that if hired, my employment is for no definite period of time and, regardless of the date of payment of wages or salary, may be terminated at any time, by myself or PTAB with or without cause, and with or without notice.

I hereby certify that all the statements and answers, which I have given in this application, are in my own handwriting and true to the best of my knowledge and I understand that PTAB may call my former employers.

SIGNATURE_____ DATE_____

(Please complete the reverse side also)

This application is valid for 30 days after the date of submission.