



Your Touchstone Energy Cooperative

P. O. Box 308, 3 South Macon Street
Reynolds, Georgia 31076
(478) 847-3415

APPLICATION FOR EMPLOYMENT

DATE OF APPLICATION: \_\_\_\_\_

It is the practice of Flint Electric Membership Corporation to accept Applications for Employment for existing vacancies only. You must submit a separate application for each position for which you desire to be considered. Complete information should be furnished in order that we may give you fair and appropriate consideration. As an Equal Opportunity Employer, it is the policy of Flint Electric Membership Corporation to afford equal employment opportunity to all individuals, regardless of race, color, religion, sex, national origin, handicap, disability, veteran status or age.

POSITION INFORMATION

Position Applying For: \_\_\_\_\_

Have you ever applied for a job with Flint Electric Membership Corporation? Yes\_\_\_\_\_ No\_\_\_\_\_
If "yes", please give the position for which you applied and the date of application. \_\_\_\_\_

Will you accept employment if offered in: Reynolds\_\_\_\_\_ Warner Robins\_\_\_\_\_ Perry\_\_\_\_\_ Upatoi\_\_\_\_\_

Date available for work: \_\_\_\_\_

Have you previously been employed with Flint Electric Membership Corporation? Yes\_\_\_\_\_ No\_\_\_\_\_
If "yes", what was your date of termination? \_\_\_\_\_

GENERAL INFORMATION

Name: \_\_\_\_\_
(Last) (First) (Middle)

Phone number(s) \_\_\_\_\_

Current Address: \_\_\_\_\_
Street (or P. O. Box) City & State Zip Code

If at the above address for less than three years, list below all residences for the past three years. Attach a separate sheet if necessary.

Street City & State Zip Code

Street City & State Zip Code

If hired, can you furnish proof that you are at least 18 years of age and eligible to work in the United States? Yes\_\_\_\_\_ No\_\_\_\_\_

If "no", please explain: \_\_\_\_\_
(If unsure of the documentation needed to prove eligibility to work in the U.S., we will explain the legal requirements.)

Have you been convicted of, or pled guilty to, a felony or been released from prison in the past 10 years? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "yes", please explain: \_\_\_\_\_  
 (Note: A "yes" answer does not automatically disqualify you from employment since the nature of the offense, date and type of job for which you are applying will be considered.)

Are you related by blood or marriage to a Flint EMC director, employee or immediate family of employee? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "yes", give name and relationship: \_\_\_\_\_

Do you have any commitments to another employer that might affect your employment with our company? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "yes", explain: \_\_\_\_\_

If hired, can you work during the hours and days required for the position for which you are applying? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "no", please explain: \_\_\_\_\_

**MILITARY STATUS**  
 Do you have any military experience that would be relevant to the job for which you are applying? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "yes", please explain: \_\_\_\_\_

<b>EDUCATION &amp; TRAINING</b>			
<b>NAME OF SCHOOL &amp; ADDRESS</b>	<b># OF YEARS COMPLETED</b>	<b>DIPLOMA / DEGREE YES / NO</b>	<b>MAJOR COURSE OF STUDY</b>
High School _____ Address _____			
College _____ Address _____			
Correspondence / Trade School _____ Address _____			
Graduate School _____ Address _____			

Do you have all of the professional licenses and certifications listed in the job announcement, job advertisement, or job description, or that are necessary in order to perform the job for which you are applying? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "no", please explain: \_\_\_\_\_

**EMPLOYMENT HISTORY (BEGIN WITH MOST RECENT)**

*(The Department of Transportation requires that driver applications show all employment for the past three years and commercial driver employment for the seven years immediately preceding this three year period. FMCSR 391.21 (b) (10), (11).*

(1) Employer _____	Position Title _____
Address _____	Duties _____
_____ Phone _____	_____
Supervisor's Name _____	_____
Dates Employed: From _____ To _____	Reason for Leaving _____
Wage / Salary _____	_____

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(2) Employer _____	Position Title _____
Address _____	Duties _____
_____ Phone _____	_____
Supervisor's Name _____	_____
Dates Employed: From _____ To _____	Reason for Leaving _____
Wage / Salary _____	_____

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(3) Employer _____	Position Title _____
Address _____	Duties _____
_____ Phone _____	_____
Supervisor's Name _____	_____
Dates Employed: From _____ To _____	Reason for Leaving _____
Wage / Salary _____	_____

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(4) Employer _____	Position Title _____
Address _____	Duties _____
_____ Phone _____	_____
Supervisor's Name _____	_____
Dates Employed: From _____ To _____	Reason for Leaving _____
Wage / Salary _____	_____

(5) Employer \_\_\_\_\_

Position Title \_\_\_\_\_

Address \_\_\_\_\_

Duties \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Supervisor's Name \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

Wage / Salary \_\_\_\_\_

(6) Employer \_\_\_\_\_

Position Title \_\_\_\_\_

Address \_\_\_\_\_

Duties \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Supervisor's Name \_\_\_\_\_

Dates Employed: From \_\_\_\_\_ To \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

Wage / Salary \_\_\_\_\_

**REFERENCES (not relatives or former employers)**

(1) Name \_\_\_\_\_

(2) Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

# Years Known \_\_\_\_\_

# Years Known \_\_\_\_\_

(3) Name \_\_\_\_\_

(4) Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

# Years Known \_\_\_\_\_

# Years Known \_\_\_\_\_

 Answer the questions on this page ONLY if you are applying for a position requiring a Commercial Driver's License (CDL).

**DRIVER EXPERIENCE & QUALIFICATION**

Date of Birth \_\_\_\_\_ The U. S. Department of Transportation requires that driver applicants state their date of birth. 391.21 (b) (2).  
Month/Day/Year

Social Security Number \_\_\_\_\_

Physical History: The U. S. Department of Transportation requires that all driver applicants pass certain physical tests before they are hired to drive for a motor carrier. FMCSR 391 Subpart E.

Date of last Department of Transportation prescribed physical examination: \_\_\_\_\_

Have you ever been granted a waiver under section 391.49 of the Federal Motor Carrier Safety Regulations pertaining to the loss of foot, leg, hand or arm? Yes \_\_\_\_\_ No \_\_\_\_\_

<b>LICENSES – DRIVER LICENSES HELD IN THE PAST 3 YEARS MUST BE LISTED</b>			
<b>STATE</b>	<b>LICENSE NUMBER</b>	<b>TYPE</b>	<b>EXPIRATION DATE</b>

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_

B. Has any license, permit or privilege ever been suspended or revoked? Yes \_\_\_\_\_ No \_\_\_\_\_

C. Have you ever been disqualified for violations of the Federal Motor Carrier Safety Regulations? Yes \_\_\_\_\_ No \_\_\_\_\_

**If you answered "yes" to A, B or C, attach a statement giving details.**

<b>DRIVING EXPERIENCE</b>				
<b>CLASS OF EQUIPMENT</b>	<b>TYPE OF EQUIPMENT (Van, Tank, Flat, etc.)</b>	<b>DATES</b>		<b>APPROXIMATE TOTAL MILES</b>
		<b>FROM</b>	<b>TO</b>	
Straight Truck				
Tractor & Semi-Trailer				
Twin Trailers				
Other				

List states operated in during the last five years: \_\_\_\_\_

List special courses or training that will help you as a driver: \_\_\_\_\_

List safe driving awards held and who awards were presented by: \_\_\_\_\_

<b>ACCIDENT REVIEW FOR THE PAST 3 YEARS (Attach a separate sheet of paper if more space is needed.)</b>			
<b>DATES</b>	<b>NATURE OF ACCIDENT (Head-On, Rear-End, etc.)</b>	<b>FATALITIES</b>	<b>INJURIES</b>

<b>TRAFFIC CONVICTIONS &amp; FOREFEITURES FOR THE PAST 3 YEARS OTHER THAN PARKING VIOLATIONS</b>			
<b>LOCATION</b>	<b>DATE</b>	<b>CHARGE</b>	<b>PENALTY</b>

**TO BE READ AND SIGNED BY APPLICANT**

I hereby authorize Flint Electric Membership Corporation to investigate all statements contained in this application. I understand that misrepresentation or omission of material facts will be a cause for immediate dismissal without notice.

I understand that passing an employment entrance examination by the Flint Electric Membership Corporation physician is required after employment has been offered to determine physical fitness as related to job requirements. The corporate physician is hereby authorized to discuss the results of the medical examination, as it relates to work activities, with the appropriate Flint Electric Membership Corporation personnel.

I certify, as a condition of my employment, that this application was completed by me, that all entries on it and information in it are true and complete to the best of my knowledge, and that I will comply with all the rules and regulations of this corporation that are in effect now and any others that may be instituted at a later date. I also agree to follow all health and safety regulations including the use of safety equipment at all times on the job.

I also authorize the release of information with regard to my character, ability, employment and habits and agree to hold any persons contacted harmless with respect to any information they may give.

Additionally, I understand that nothing contained in this employment application or in the granting of an interview or in any policies, procedures or handbooks that I might receive, is intended to provide an employment contract between Flint Electric Membership Corporation and myself. No promises regarding employment have been made to me, and I understand that no promise or guarantee is binding upon the Corporation. If an employment relationship is established, I understand that I have the right to terminate my employment at any time, for any reason, or for no reason, and that Flint Electric Membership Corporation retains a similar right regarding the discontinuation of my employment, subject to the full extent of the law.

I understand that my employment is conditioned also upon the results of an employment entrance urine drug screen for which I submitted or will submit a specimen for testing. I realize that any positive result, not caused by the presence of a legitimately prescribed prescription drug, will cause my being refused employment or dismissed if the results of the test are received after my initial employment date.

\_\_\_\_\_  
**APPLICANT SIGNATURE**

\_\_\_\_\_  
**DATE**

**FOR OFFICE USE – TO BE COMPLETED BY HIRING MANAGER OF CORPORATE SERVICES**

**HIRE**

Position Title \_\_\_\_\_ Department \_\_\_\_\_

Base Salary Offered \$ \_\_\_\_\_ Salary Grade \_\_\_\_\_

Justification \_\_\_\_\_

Date of Offer of Employment \_\_\_\_\_

**REJECT**

Reason \_\_\_\_\_

Hiring Supervisor/Manager \_\_\_\_\_ Date \_\_\_\_\_

**DISPOSITION**

\_\_\_\_\_  
Employment Offered and Accepted      Start Date \_\_\_\_\_

\_\_\_\_\_  
Employment Offered and Declined      Reason \_\_\_\_\_

Sr. Vice President of Corporate Services \_\_\_\_\_ Date \_\_\_\_\_

**FLINT ELECTRIC MEMBERSHIP CORPORATION  
EEO SELF-IDENTIFICATION FORM**

Flint Energies is an equal opportunity employer. All applicants are considered without regard to race, color, religion, sex, age, national origin, veteran status, disability or any status that is protected by state or federal law.

In an effort to comply with government record keeping requirements, we ask that you **voluntarily** complete this information. The U.S. government requires employers to report the number of their applicants and employees in the racial, ethnic and veteran groups listed below. While employers are permitted to determine the group identification listed below by visual survey, we believe that in order to avoid mistake and misunderstanding, every applicant should have the opportunity to answer this question personally. **THIS INFORMATION WILL ONLY BE USED FOR REPORTING TO GOVERNMENTAL AGENCIES. IT WILL NOT BE USED IN DETERMINING ELIGIBILITY FOR EMPLOYMENT AND WILL BE KEPT SEPARATE FROM THE APPLICATION FORM.**

=====  
Name: \_\_\_\_\_ Date: \_\_\_\_\_

Position applying for: \_\_\_\_\_

Current Address: \_\_\_\_\_  
Street (or P. O. Box) City & State Zip Code County

How did you learn of this vacancy? \_\_\_\_\_

If by advertisement, please give name and date of publication: \_\_\_\_\_

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**PART I - SEX, RACE, AND ETHNICITY** *(The following designations are those currently required by the Federal Government.)*

Check One Only: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE

Are you Hispanic or Latino? \_\_\_\_\_ YES \_\_\_\_\_ NO  
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.)

If NO, Check One Only:

\_\_\_\_\_ **White** (Not Hispanic or Latino) - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

\_\_\_\_\_ **Black or African American** (Not Hispanic or Latino) - A person having origins in any of the black racial groups of Africa.

\_\_\_\_\_ **Native Hawaiian or Other Pacific Islander** (Not Hispanic or Latino) - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

\_\_\_\_\_ **Asian** (Not Hispanic or Latino) - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

\_\_\_\_\_ **American Indian or Alaskan Native** (Not Hispanic or Latino) - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

\_\_\_\_\_ **Two or More Races** (Not Hispanic or Latino) - All persons who identify with more than one of the above five races.

**PART II - IDENTIFICATION AS COVERED VETERAN**

Check ALL That Apply:

         **Disabled Veteran:** This term means (i) a veteran of the U. S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs, or (ii) a person who was discharged or released from active duty because of a service-connected disability.

         **Active duty wartime or campaign badge Veteran:** This term means a veteran who served on active duty in the U. S. Military, ground, naval, or air service during a war or in a campaign or expedition for which a campaign badge has been authorized under the laws of the Department of Defense.

         **Armed Forces Service Medal Veteran:** This term means a veteran who, while serving on active duty in the U. S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 Fed. Reg. 1209).

         **Recently Separated Veteran:** This term means a veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U. S. military, ground, naval or air service.

**PART III – DISABLED**

Check One Only:             YES             NO

Any individual who (1) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (2) has a record of such impairment, or (3) is regarded as having such an impairment. ("Substantially limited" means an impairment that is "likely" to cause you to experience difficulty in securing, retaining or advancing in employment.)

All job qualification requirements must be job related and all information obtained from medical examinations and pre-employment inquiries will be used in accordance with job related standards. "Substantially limited" is added to clarify the meaning of that phrase for the purposes of these regulations. A definition of a qualified disabled individual is provided to assure that persons who are protected under the Act are those qualified to work rather than those who qualify solely to meet the definition of disabled. All physical and mental qualifications must be justified for the particular job for which the disabled person is being considered.

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\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
DATE

**(see next page)**



# Voluntary Self-Identification of Disability

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](http://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: \_\_\_\_\_