



TODAY'S DATE:
/ /

Thank you for your interest in applying for a job with Smith Dairy. Please answer the following questions honestly and completely. Please use a pen to complete the form.

PERSONAL DATA

NAME(LAST)	(FIRST)	(MI)	SOCIAL SECURITY NUMBER ----
------------	---------	------	--------------------------------

PRESENT ADDRESS	STREET	CITY	STATE(ZIP CODE)	PHONE ()	CELL ()
-----------------	--------	------	-----------------	-----------	----------

ARE YOU A CITIZEN OF THE U.S. OR DO YOU HAVE A RIGHT TO WORK IN THE U.S.? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YOU WERE PREVIOUSLY INTERVIEWED OR EMPLOYED AT SMITH DAIRY PLEASE STATE THE DATES OF EMPLOYMENT, OR WHEN INTERVIEWED.
ARE YOU 18 YEARS OF AGE OR OLDER? YES <input type="checkbox"/> NO <input type="checkbox"/>	

PLEASE INDICATE IF YOU WERE EMPLOYED UNDER A DIFFERENT NAME

DO YOU OR HAVE YOU USED TOBACCO PRODUCTS ON A REGULAR BASIS WITHIN THE LAST YEAR? YES NO

LIST RELATIVES/ACQUAINTANCES THAT ARE CURRENTLY EMPLOYED AT SMITH DAIRY _____

EDUCATIONAL DATA

	NAME, CITY & STATE	DATES ATTENDED *		GRADUATED		MAJOR
		FROM Mo Yr	TO Mo Yr	YES	NO	
HIGH SCHOOL		N/A	N/A			N/A
COLLEGE/ OTHER						
GRADUATE SCHOOL						

**Information required to secure records and all pertinent data from school officials*

Are you presently enrolled in school? YES NO If yes, where enrolled _____

List states and counties of residence for the past seven years.

Have you ever been discharged or asked to resign by an employer? Yes No Have you ever been suspended from a job? Yes No
If yes to either question, please explain:

Have you **ever** been convicted or pleaded guilty to a crime, including motor vehicle citations that your license was revoked or suspended for a period of time? YES NO If yes, please explain in detail. If you need more space, use page 4 of this application. Conviction of a felony will not automatically disqualify you from employment.

AVAILABILITY

Check desired work: Office ___ Factory ___ Truck Driver ___ Truck Mechanic ___ Plant Maintenance ___ Other _____

Full Time ___ Part Time ___ If part time, how many hours a week can you work? _____

Seasonal work ___ If seasonal, what are your potential starting and ending dates: ___/___/___ to ___/___/___

Please complete this section if the job for which you are applying might require you to drive company vehicles:

Check license type: Class A CDL ___ Years Experience _____ Class B CDL ___ Years Experience _____

Straight truck driving ___ Years Experience _____

Are you over 25 years of age? Yes ___ No ___ Have you had any accidents in the last 5 years? Yes ___ No ___ If yes, explain:

Has your driver's license ever been suspended, revoked, denied or cancelled? Yes ___ No ___ If yes, explain:

EMPLOYMENT HISTORY

Beginning with your present or most recent employer, describe your employment experiences below. Account for any time during this period that you were unemployed by stating the nature of your activities. Please attach additional sheets if necessary.

Are you on layoff and subject to recall? YES NO

COMPANY NAME/CITY, STATE/TELEPHONE NUMBER: ()	IMMEDIATE SUPERVISOR:
	YOUR JOB TITLE OR POSITION:

DATES EMPLOYED		STARTING WAGE OR SALARY :	PRESENT/FINAL WAGE OR SALARY:	IF STILL EMPLOYED, MAY WE CONTACT YOUR PRESENT EMPLOYER? YES <input type="checkbox"/> NO <input type="checkbox"/>
From: (Mo./Yr.)	To: (Mo./Yr.)			

REASONS FOR LEAVING:

DESCRIBE YOUR DUTIES:

COMPANY NAME/CITY, STATE/TELEPHONE NUMBER: ()	IMMEDIATE SUPERVISOR:
	YOUR JOB TITLE OR POSITION:

DATES EMPLOYED		STARTING WAGE OR SALARY:	FINAL WAGE OR SALARY:	REASONS FOR LEAVING:
From: (Mo/Yr)	To: (Mo/Yr)			

DESCRIBE YOUR DUTIES:

COMPANY NAME/CITY, STATE/TELEPHONE NUMBER: ()	IMMEDIATE SUPERVISOR:
	YOUR JOB TITLE OR POSITION:

DATES EMPLOYED		STARTING WAGE OR SALARY:	FINAL WAGE OR SALARY:	REASONS FOR LEAVING:
From: (Mo/Yr)	To: (Mo/Yr)			

DESCRIBE YOUR DUTIES:

Next previous employer name, city, state: _____ Phone() _____
 Name and title of Supervisor _____
 Dates employed: From (Mo/Yr) ____ / ____ To (Mo/Yr) ____ / ____

Next previous employer name, city, state: _____ Phone() _____
 Name and title of Supervisor _____
 Dates employed: From (Mo/Yr) ____ / ____ To (Mo/Yr) ____ / ____

OTHER ACCOMPLISHMENTS

Please list below any other job related accomplishments, professional distinctions, certifications, or verifiable volunteer work

PROFESSIONAL REFERENCES

(Do not list relatives)

NAME	ADDRESS	OCCUPATION/TELEPHONE #
		Occupation: Telephone # ()
		Occupation: Telephone # ()
		Occupation: Telephone # ()

MILITARY EXPERIENCE:
 What branch have you served in with the United States Armed Services? _____

Please read the following paragraph carefully! By signing below, I certify that I have read, understand and agree to each of the following statements: All of the information that I have supplied on this application is true, accurate and complete to the best of my knowledge, and I have not knowingly withheld any information which, if known to Smith Dairy, would affect my application unfavorably. If I am hired by Smith Dairy, and if Smith Dairy discovers at any time during my employment that any of the statements or answers on this application are false, misleading, or incomplete, I may be dismissed immediately from my job. This employment application will be considered active for 365 days from the date below. If I want to be considered for a job with Smith Dairy after this period of time, I must fill out another application. I agree to submit to a medical examination, which may include testing for drugs or alcohol, prior to beginning work with Smith Dairy. In consideration for my employment with Smith Dairy, I agree to abide by all Smith Dairy rules and regulations. I agree to release to Smith Dairy or its designated agents all medical information including, but not limited to files, reports, x-rays, evaluations, and opinions held by medical personnel, to the extent such information is job related and consistent with Smith Dairy's business needs. I acknowledge that this is a general release and that if hired, it remains in effect for the duration of my employment. In the event of my personal indebtedness to Smith Dairy, I authorize Smith Dairy to withhold from my wages such amount permitted by law to satisfy my obligation to Smith Dairy. I give Smith Dairy my permission to conduct any investigation regarding the information contained in my employment application, which Smith Dairy thinks is necessary to determine my qualifications for assuming a job with Smith Dairy. I give Smith Dairy my permission to contact any former employer, school, college or university, utility company, credit or finance bureau or office, any personal or professional reference, sources may have about my character, general reputation, credit, education, or employment record, and I give my consent to any such source to release to Smith Dairy whatever information they have about me. I also unconditionally release all named and unnamed sources from any and all liability which might result from furnishing any information about me.

SIGNATURE	DATE
------------------	-------------

Smith Dairy is an Equal Opportunity Employer and does not discriminate on the basis of race, color, religion, sex, national origin, age, marital status, veteran status, handicap or disability.

Rev 11/08



Smith Dairy's Vision

Smith Dairy will be the preferred dairy products supplier to consumers, retailers, food service warehouses, and manufacturers.

We will be responsible stewards of our business as we continually improve quality, service, efficiency, and profitability.

Our commitment to treating customers, associates, and owners according to Christ's example will guide our actions.

OTHER COMMENTS

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

