



South Central Regional Transit District

ALL APPLICANTS MUST HAVE A CDL—with PASSENGER ENDORSEMENT

ALL APPLICANTS MUST PROVIDE:

SCRTD requires a record check and a printout from the MVD from all applicants.

You can obtain your driving record at the Department of Motor Vehicles. A copy of your driving license.

Once completed return both items with your application.

Position Application submit to the following location:

**830 Anthony Drive
Anthony, NM 88021**

**Contact Sara Vasquez
(575) 613-3923**

Additional position details located on the SCRTD website at scrttd.org

Application for Employment

In compliance with Federal and State equal employment opportunity laws, qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital status, veteran status, non-job related disability, or any other protected group status.

Applicant Name _____ Date of Application _____
(Please Print)

Company _____

Address _____

City _____ State _____ Zip _____

TO BE READ AND SIGNED BY APPLICANT

I authorize you to make such investigations and inquiries of my personal, employment, credit, criminal or medical history and other related matters as may be necessary in arriving at an employment decision. (Generally, inquiries regarding medical history will be made only if and after a conditional offer of employment has been extended.) I hereby release employers, schools, health care providers and other persons from all liability in responding to inquiries and releasing information in connection with my application.

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 Company

I understand that information I provide regarding current and/or previous employers may be used, and those employer(s) will be contacted, for the purpose of investigating my safety performance history as required by 49 CFR 391.23 (d) and (e). I understand that I have the right to:

- Review information provided by previous employers;
- Have errors in the information corrected by previous employers and for those previous employers to re-send the corrected information to the prospective employer: and
- Have a rebuttal statement attached to the alleged erroneous information, if the previous employer(s) and I cannot agree on the accuracy of the information.

My signature establishes that I fully understand the above statements:

* Signature _____

FOR COMPANY USE

PROCESS RECORD

Applicant Hired _____ Rejected _____

Date Employed _____ Point Employed _____

Department _____ Classification _____

(IF REJECTED, SUMMARY REPORT OF REASON (S) SHOULD BE PLACED IN FILE)

Signature of Interviewing Officer _____

TERMINATION OF EMPLOYMENT

Date Terminated _____ Department Released From _____

Dismissed _____ Voluntarily Quit _____ Other _____

Termination Report Place in File _____ Supervisor _____

APPLICANT TO COMPLETE
(answer all questions – please print)

Position Applied For

Name LAST FIRST MIDDLE Social Security No.

List your address of residency for the past 3 years.

Current Address

Street

City

State

Zip

Phone

How Long?

Previous Address

Street

City State

Zip

Phone

How Long?

Street

City State

Zip

Phone

How Long?

Street

City State

Zip

Phone

How Long?

Do you have the legal right to work in the United States?

Date of Birth

/

/

Can you provide proof of age?

(Required for Commercial Drivers)

Have you worked for this company before?

Where?

Dates: From

To

Rate of Pay

Position

Reason for leaving

Are you now employed?

If not, how long since leaving last employment

Who referred you


Rate of pay expected?


Is there any reason you might be unable to perform the functions of the job for which you have applied (as described in the attached job description)?


If yes, explain if you wish. _____


EMPLOYMENT HISTORY


All driver applicants to drive in Interstate commerce must provide the following information on all employers during the preceding 3 years. List complete mailing address, street number, city, state and zip code. Applicants to drive a commercial motor vehicle in Intrastate or Interstate commerce shall also provide an additional 7 years information on those employers for whom the applicant operated such vehicle.


| EMPLOYER | | DATE | |
|---|--------------------------------|---------------------|------------------|
| NAME | | FROM MO. YR. | TO MO. YR. |
| ADDRESS | | POSITION HELD | |
| CITY | STATE ZIP | SALARY/ WAGE | |
| CONTACT PERSON | PHONE NUMBER | REASON FOR LEAVING? | |
| WERE YOU SUBJECT TO THE FMCSRS  WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |

| EMPLOYER | | DATE | |
|---|--------------------------------|---------------------|------------------|
| NAME | | FROM MO. YR. | TO MO. YR. |
| ADDRESS | | POSITION HELD | |
| CITY | STATE ZIP | SALARY/ WAGE | |
| CONTACT PERSON | PHONE NUMBER | REASON FOR LEAVING? | |
| WERE YOU SUBJECT TO THE FMCSRS  WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |


| EMPLOYER | | DATE | |
|---|--------------------------------|---------------------|------------------|
| NAME | | FROM MO. YR. | TO MO. YR. |
| ADDRESS | | POSITION HELD | |
| CITY | STATE ZIP | SALARY/ WAGE | |
| CONTACT PERSON | PHONE NUMBER | REASON FOR LEAVING? | |
| WERE YOU SUBJECT TO THE FMCSRS  WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |

| EMPLOYER | | DATE | |
|---|--------------------------------|---------------------|------------------|
| NAME | | FROM MO. YR. | TO MO. YR. |
| ADDRESS | | POSITION HELD | |
| CITY | STATE ZIP | SALARY/ WAGE | |
| CONTACT PERSON | PHONE NUMBER | REASON FOR LEAVING? | |
| WERE YOU SUBJECT TO THE FMCSRS  WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |

| EMPLOYER | | DATE | |
|---|--------------|---------------------|---------------|
| NAME | | FROM MO. YR. | TO MO. YR. |
| ADDRESS | | POSITION HELD | |
| CITY | STATE ZIP | SALARY/ WAGE | |
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| WERE YOU SUBJECT TO THE FMCSRS  WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |

| EMPLOYER | | DATE | |
|---|--------------|---------------------|---------------|
| NAME | | FROM MO. YR. | TO MO. YR. |
| ADDRESS | | POSITION HELD | |
| CITY | STATE ZIP | SALARY/ WAGE | |
| CONTACT PERSON | PHONE NUMBER | REASON FOR LEAVING? | |
| WERE YOU SUBJECT TO THE FMCSRS  WHILE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |

*Includes vehicles having a GVWR of 26,001lbs or more, vehicles designed to transport 15 or more passengers, or any size vehicle used to transport hazardous materials in a quantity requiring placarding.

 The Federal Motor Carrier Safety Regulations (FMCSRSs) apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle (1) weighs or has a GVWR of 10,001 pounds or more, (2) is designed or used to transport 9 or more passengers, OR (3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

ACCIDENT RECORD FOR THE PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED) IF NONE, WRITE NONE

| DATE STARTING WITH MOST RECENT | NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC) | FATALITIES | INJURIES | HAZARDOUS MATERIAL SPILL |
|--------------------------------------|---|------------|----------|-----------------------------|
| | | | | |
| | | | | |
| | | | | |

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS) IF NONE, WRITE NONE

| LOCATION | DATE | CHARGE | PENALTY |
|----------|------|--------|---------|
| | | | |
| | | | |
| | | | |

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS –DRIVER ONLY

List all driver licenses or permits held in the past 3 years.

| STATE | LICENSE NO | TYPE | EXPIRATION DATE |
|-------|------------|------|-----------------|
| | | | |
| | | | |
| | | | |

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? Yes _____ No _____
 B. Have any licenses, permit or privilege ever been suspended or revoked? Yes _____ No _____
 IF THE ANSWER TO EITHER A OR B IS YES, GIVE DETAILS _____

DRIVING EXPERIENCE, CHECK YES OR NO

| CLASS OF EQUIPMENT | CIRCLE TYPE OF EQUIPMENT | DATES From (M/Y) To (M/Y) | APPROX. NO. OF MILES (TOTAL) |
|---|--------------------------------|---------------------------|------------------------------|
| STRAIGHT TRUCK <input type="checkbox"/> YES <input type="checkbox"/> NO | (VAN, TANK, FLAT, DUMP, REFER) | | |
| TRACTOR & SEMI TRAILER <input type="checkbox"/> YES <input type="checkbox"/> NO | (VAN, TANK, FLAT, DUMP, REFER) | | |
| TRACTOR TWO TRAILERS <input type="checkbox"/> YES <input type="checkbox"/> NO | (VAN, TANK, FLAT, DUMP, REFER) | | |
| TRACTOR THREE TRAILERS <input type="checkbox"/> YES <input type="checkbox"/> NO | (VAN, TANK, FLAT, DUMP, REFER) | | |
| MOTORCOACH SCHOOL BUS <input type="checkbox"/> YES <input type="checkbox"/> NO More than 8 passengers | | | |
| MOTORCOACH SCHOOL BUS <input type="checkbox"/> YES <input type="checkbox"/> NO More than 16 passengers | | | |
| OTHER | | | |

LIST STATES OPERATED IN FOR LAST FIVE YEARS _____

SHOW SPECIAL COURSES OR TRAINING THAT WILL HELP YOU AS A DRIVER: _____

WHICH SAFE DRIVING AWARDS DO YOU HOLD AND FROM WHOM? _____

EXPERIENCE AND QUALIFICATIONS – OTHER _____

SHOW ANY TRUCKING, TRANSPORTATION OR OTHER EXPERIENCE THAT MAY HELP IN YOUR WORK FOR THIS COMPANY. _____

LIST COURSES AND TRAINING OTHER THAN SHOWN ELSEWHERE IN THIS APPLICATION _____

LIST SPECIAL EQUIPMENT OR TECHNICAL MATERIALS YOU CAN WORK WITH (OTHER THAN THOSE ALREADY SHOWN) _____

EDUCATION

CIRCLE HIGHEST GRADE COMPLETED: 1 2 3 4 5 6 7 8 HIGH SCHOOL: 1 2 3 4 COLLEGE: 1 2 3 4

LAST SCHOOL ATTENDED

NAME

CITY

STATE

TO BE READ AND SIGNED BY APPLICANT

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

Signature: _____

Date _____

This questionnaire may be used to identify a worker's physical ability to perform the job he/she has been conditionally hired or contracted and/or to analyze or evaluate workers' compensation claims submitted in the future.

MEDICAL QUESTIONNAIRE

PLEASE PRINT

Name:

Address

Date of Birth

Social Security Number

In Case of Emergency (Name, Phone #, & Relationship)

Have you ever suffered a work related injury? Yes No

Have you ever filed for and/or received Workers' Compensation benefits? Yes No
If yes, list dates and describe when such claims were filed, and /or benefits were received.

Have you ever suffered an illness or injury other than at work where you were off work, and/or had to limit your activities for more than one week? Yes No
If yes, list dates and describe all such injuries, and/or illness suffered.

Have you ever been in an automobile accident? Yes No
If yes, list dates of all such accidents, all injuries suffered including any physical restrictions imposed.

List your family physician

Please check any of the following activities for which you have, or have had, a restriction:

- Lifting Standing Squatting Carrying Walking Crawling Sitting Bending Climbing

Give a brief description of any restrictions checks above.

EMPLOYEE NOTICE

Pursuant to NMSA 1991, 52-1-28.3 (The New Mexico Workers' Compensation Act the worker shall be entitled to **NO** future workers compensation benefits if he/she knowingly and willfully conceals or makes a false representation about the information requested.

I certify that the information listed above is true, correct and complete, to the best of my knowledge and that I understand all the questions listed in this questionnaire. I further certify that I have read and understand the above Notice provision indicating that I will be entitled to **NO** future workers compensation benefits if I knowingly and willfully conceal or makes a false representation about the information requested.

Print Name

Company Representative

Signature

Signature

Date

Date

Name _____

Date _____

1. What are the three most important things you look for in a job? _____

2. What three qualities or strengths can you bring to the job? _____

3. Preferred hours and days: _____ Do you prefer full-time or part-time work? _____

4. Are you a morning/day person or are you an afternoon/evening person? _____

5. Are there days or times you cannot or will not work? _____ please explain

6. Are there holidays you cannot work? _____ If so, what holiday(s)? _____

7. How is your night vision? _____

8. This job involves considerable lifting and loading. The shifts can last 10-12 hours. Do you feel confident that you can meet the challenge? _____

Signature _____

Thank you for applying with the SCRTD.