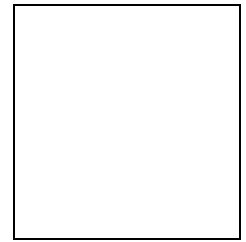




APPLICATION FOR EMPLOYMENT



PLEASE READ CAREFULLY.
 ALL INFORMATION WILL BE TREATED CONFIDENTIALLY. PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE.
 THE USE OF THIS FORM DOES NOT INDICATE THAT THERE ARE POSITIONS OPEN AND DOES NOT OBLIGATE YOU OR COX & COMPANY, INC. (COX). FEDERAL LAW PROHIBITS DISCRIMINATION ON THE BASIS OF RACE, SEX, AGE, RELIGION, COLOR OR NATIONAL ORIGIN. PLEASE PRINT IN INK.

PERSONAL			
LAST NAME:	FIRST NAME:	MIDDLE:	TODAY'S DATE:
ADDRESS:			SOCIAL SECURITY NUMBER:
CITY:	STATE:	ZIP:	TELEPHONE NUMBER:
WORK PHONE:	EMAIL:	OTHER CONTACTS:	
ARE YOU A UNITED STATES CITIZEN?	ARE YOU ELIGIBLE FOR EMPLOYMENT IN THE UNITED STATES?	IF NO, DO YOU HAVE A VISA THAT ALLOWS EMPLOYMENT?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF SO, WHAT TYPE OF VISA?			

GENERAL									
POSITION(S) APPLYING FOR:	DATE AVAILABLE TO START:	SALARY REQUIREMENT:	AVAILABILITY						
			<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> SUMMER						
HAVE YOU EVER BEEN EMPLOYED BY COX?			- INDICATE HOURS AVAILABLE						
<input type="checkbox"/> YES IF YES, PLEASE COMPLETE: <input type="checkbox"/> NO DEPARTMENT: _____ SUPERVISOR: _____			MON	TUE	WED	THUR	FRI	SAT	SUN
<input type="checkbox"/> YES IF YES, PLEASE COMPLETE: <input type="checkbox"/> NO DEPARTMENT: _____ SUPERVISOR: _____									
HOW WERE YOU REFERRED TO THE HUMAN RESOURCES OFFICE?			<input type="checkbox"/> VOLUNTARY <input type="checkbox"/> STATE/OTHER EMPLOYMENT OFFICE: _____ <input type="checkbox"/> COX EMPLOYEE _____						
<input type="checkbox"/> WANT AD: _____ <input type="checkbox"/> PRIVATE EMPLOYMENT AGENCY: _____ <input type="checkbox"/> OTHER: _____			(IE. 6-11 AM, 3-9PM)						
HAVE YOU EVER WORKED FOR THIS COMPANY UNDER A DIFFERENT NAME? IS ADDITIONAL INFORMATION RELATIVE TO NAME CHANGE, ASSUMED NAME OR NICKNAME NECESSARY TO ENABLE A CHECK OF YOUR WORK RECORD? IF YES, PLEASE EXPLAIN:									
<input type="checkbox"/> YES <input type="checkbox"/> NO									
*DO YOU HAVE ANY HEALTH-RELATED CONDITIONS THAT MIGHT INTERFERE WITH YOUR ABILITY TO SATISFY AND EFFICIENTLY PERFORM ALL DUTIES OF THE JOB FOR WHICH YOU ARE APPLYING? *DO NOT ANSWER UNTIL YOU HAVE RECEIVED AN OFFER OF EMPLOYMENT FROM COX & COMPANY, INC. IF YES, ARE THERE ANY REUSABLE ACCOMMODATIONS THAT WOULD ENABLE YOU TO PERFORM ALL DUTIES OF THE JOB? PLEASE STATE:									
<input type="checkbox"/> YES									
<input type="checkbox"/> NO									

EDUCATION

CIRCLE HIGHEST GRADE LEVEL COMPLETED		GRADE/HIGH SCHOOL											COLLEGE						
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6+
SCHOOL	NAME & LOCATION	MAJOR											Did you Graduate?	Certificate / Degree/Diploma					
GRADUATE	NAME												<input type="checkbox"/> YES						
	ADDRESS													<input type="checkbox"/> NO					
	CITY	STATE	ZIP																
COLLEGE	NAME												<input type="checkbox"/> YES						
	ADDRESS													<input type="checkbox"/> NO					
	CITY	STATE	ZIP																
BUSINESS/ TRADE/ TECHNICAL	NAME												<input type="checkbox"/> YES						
	ADDRESS													<input type="checkbox"/> NO					
	CITY	STATE	ZIP																
HIGH SCHOOL	NAME												<input type="checkbox"/> YES						
	ADDRESS													<input type="checkbox"/> NO					
	CITY	STATE	ZIP																

DO YOU HOLD OR HAVE HELD ANY FAA LICENSES AND/OR CERTIFICATIONS? IF YES, PLEASE IDENTIFY:

NOTE: THIS IS A DRUG-FREE WORKPLACE. ALL APPLICANTS AND EMPLOYEES HIRED FOR SAFETY SENSITIVE POSITIONS COVERED UNDER THE FAA REGULATIONS 14 CFR PARTS 121, 135 AND 49 CFR PART 40 ARE SUBJECT TO SUBSTANCE ABUSE TESTING AS A CONDITION OF HIRING AND CONTINUED EMPLOYMENT. DRUGS TESTED FOR: MARIJUANA, COCAINE, PCP, OPIATES AND AMPHETAMINES.

LIST ALL CURRENT LICENSES AND/OR AREAS OF CERTIFICATION (IF NOT INDICATED ABOVE):

LIST ALL EQUIPMENT (OFFICE, TRADE OR LABORATORY) THAT YOU OPERATE PROFICIENTLY:

LIST ANY OTHER TRAINING, SKILLS, APTITUDES AND QUALIFICATIONS WHICH YOU FEEL ARE RELEVANT TO THE TYPE OF EMPLOYMENT YOU ARE SEEKING:

HAVE YOU EVER SERVED IN THE UNITED STATES ARMED FORCES OR IN A STATE MILITIA? IF YES, WHAT BRANCH:

YES
 NO

DATE OF ACTIVE SERVICE:
FROM: _____ TO: _____

RANK AT DISCHARGE:

EMPLOYMENT

COMPANY NAME:	EMPLOYED FROM:	TO:
	MONTH: _____ YEAR: _____	MONTH: _____ YEAR: _____
ADDRESS:	STARTING SALARY:	ENDING SALARY:
	NAME OF SUPERVISOR:	
TELEPHONE NUMBER:	REASON FOR LEAVING:	
JOB TITLE AND DUTIES		

COMPANY NAME:	EMPLOYED FROM:	TO:
	MONTH: _____ YEAR: _____	MONTH: _____ YEAR: _____
ADDRESS:	STARTING SALARY:	ENDING SALARY:
	NAME OF SUPERVISOR:	
TELEPHONE NUMBER:	REASON FOR LEAVING:	
JOB TITLE AND DUTIES:		

COMPANY NAME:	EMPLOYED FROM:	TO:
	MONTH: _____ YEAR: _____	MONTH: _____ YEAR: _____
ADDRESS:	STARTING SALARY:	ENDING SALARY:
	NAME OF SUPERVISOR:	
TELEPHONE NUMBER:	REASON FOR LEAVING:	
JOB TITLE AND DUTIES:		

COMPANY NAME:	EMPLOYED FROM:	TO:
	MONTH: _____ YEAR: _____	MONTH: _____ YEAR: _____
ADDRESS:	STARTING SALARY:	ENDING SALARY:
	NAME OF SUPERVISOR:	
TELEPHONE NUMBER:	REASON FOR LEAVING:	
JOB TITLE AND DUTIES:		

IF CURRENTLY EMPLOYED, MAY YOUR EMPLOYER BE CONTACTED AT THIS TIME FOR A REFERENCE? Yes No

STATEMENT

PLEASE READ CAREFULLY BEFORE SIGNING:

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN THIS APPLICATION IS TRUE AND COMPLETE. I UNDERSTAND AND AGREE THAT ANY FALSE INFORMATION, MISREPRESENTATION OR CONCEALMENT OF FACT IS SUFFICIENT GROUNDS FOR EITHER IMMEDIATE DISCHARGE WITHOUT RECOURSE OR REFUSAL OF EMPLOYMENT BY COX & COMPANY, INC.

I UNDERSTAND AND AGREE THAT COX & COMPANY, INC. MAY VERIFY ALL INFORMATION IN THIS APPLICATION. I ALSO UNDERSTAND THAT ANY EMPLOYMENT IS SUBJECT TO A SATISFACTORY CHECK OF REFERENCES AND SATISFACTORY RESULTS OF ANY MEDICAL EXAMINATION. I HEREBY AUTHORIZE ALL INDIVIDUALS AND ORGANIZATIONS NAMES OR REFERRED TO MY EMPLOYMENT, WORK HABIT AND CHARACTER AND HEREBY RELEASE SUCH INDIVIDUALS, ORGANIZATIONS AND COX & COMPANY, INC. FROM ANY LIABILITY FOR ANY CLAIM OR DAMAGE WHICH MAY RESULT.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND EACH OF THE ABOVE STATEMENTS.

SIGNATURE: _____ DATE: _____

APPLICANT – DO NOT WRITE BELOW THIS LINE

DATE INTERVIEWED:

INTERVIEWED BY:

COMMENTS:

DATE OF 2ND INTERVIEW:

INTERVIEWED BY:

COMMENTS:

EVALUATION

SPELLING:

GRAMMAR:

JOB CLASS:

TECHNICAL

TYPING:

CATEGORY:

1 2 3 4 5 6 7 8

HIRE?

REASON FOR REJECTION:

YES

NO

START DATE:

STARTING SALARY:

PER:

POSITION:

DEPARTMENT:

BY:

DATE:

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2020
Page 1 of 2

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.¹ To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I 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:

- Blindness
- Autism
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Deafness
- Cerebral palsy
- Major depression
- Obsessive compulsive disorder
- Cancer
- HIV/AIDS
- Multiple sclerosis (MS)
- Impairments requiring the use of a wheelchair
- Diabetes
- Schizophrenia
- Missing limbs or partially missing limbs
- Intellectual disability (previously called mental retardation)
- Epilepsy
- Muscular dystrophy

Please check one of the boxes below:

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

Your Name

Today's Date

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2020
Page 2 of 2

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

ⁱ Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

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.

VOLUNTARY AFFIRMATIVE ACTION INFORMATION

<p>GENDER</p>	<p>FEMALE MALE DECLINE TO IDENTIFY</p>
<p>ETHNIC/RACE ARE YOU HISPANIC OR LATINO?</p>	<p>YES NO DECLINE TO IDENTIFY</p>
<p>IF NO, WHAT RACE DO YOU MOST CLOSELY ASSOCIATE WITH?</p>	<p>WHITE (NOT HISPANIC OR LATINO) BLACK OR AFRICAN AMERICAN (NOT HISPANIC OR LATINO) ASIAN (NOT HISPANIC OR LATINO) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER (NOT HISPANIC OR LATINO) AMERICAN INDIAN OR ALASKAN NATIVE (NOT HISPANIC OR LATINO) TWO OR MORE RACES (NOT HISPANIC OR LATINO) DECLINE TO IDENTIFY (NOT HISPANIC OR LATINO)</p>
<p>PROTECTED VETERANS – (ONE OR MORE OF THE FOUR VETERAN CATEGORIES) REGULATIONS ISSUED BY THE US DEPT OF LABOR WITH RESPECT TO HANDICAPPED INDIVIDUALS, DISABLE VETERANS, AND VIETNAM ERA VETERANS REQUIRE THAT FEDERAL CONTRACTORS PROVIDE A SELF-IDENTIFICATION OPPORTUNITY TO EMPLOYEES AND APPLICANTS FOR EMPLOYMENT. SUCH SELF-IDENTIFICATION AND ANY INFORMATION PROVIDED ARE SUBMITTED ON (A) A VOLUNTARY BASIS, (B) ON A CONFIDENTIAL BASIS, (C) FOR USE ONLY IN ACCORDANCE WITH REGULATIONS, AND (D) WITHOUT SUBJECTING THE INDIVIDUAL TO ADVERSE TREATMENT. SELF-IDENTIFICATION AND REQUESTS FOR ACCOMMODATIONS MAY BE MADE NOW OR AT ANY TIME IN THE FUTURE.</p> <p>THE VIETNAM ERA VETERANS’ READJUSTMENT ASSISTANCE ACT OF 1974 (VEVRAA) REQUIRES GOVERNMENT CONTRACTORS TO TAKE AFFIRMATION ACTION TO EMPLOY AND ADVANCE IN EMPLOYMENT (1)DISABLED VETERANS, (2) RECENTLY SEPARATED VETERANS, (3) ACTIVE DUTY WARTIME OR CAMPAIGN BADGE VETERANS, AND (4) ARMED FORCES SERVICE MEDAL VETERANS.</p> <p align="center"> I WISH TO IDENTIFY AS A PROTECTED VETERAN I AM NOT A PROTECTED VETERAN DECLINE TO IDENTIFY </p>	
<p>REGULATIONS ISSUED BY THE US DEPT. OF LABOR REQUIRE THAT FEDERAL CONTRACTORS REACH OUT TO, RECRUIT AND PROVIDE EQUAL OPPORTUNITY TO QUALIFIED PEOPLE WHO HAVE DISABILITIES. YOUR SUBMISSION OF INFORMATION IS VOLUNTARY. INFORMATION YOU PROVIDE WILL BE KEPT CONFIDENTIAL IN ACCORDANCE WITH FEDERAL LAW, AND WILL NOT AFFECT OUR CONSIDERATION OF YOUR JOB APPLICATION OR SUBJECT YOU TO NEGATIVE TREATMENT OR ANY KIND.</p>	
<p>PLEASE INDICATE WHETHER YOU HAVE A DISABILITY</p>	<p>YES, I HAVE A DISABILITY (OR HAVE PREVIOUSLY HAD A DISABILITY) NO, I DON'T WISH TO IDENTIFY AS HAVING A DISABILITY</p>
<p>TO ALL APPLICANTS AND PERSONNEL: THIS VOLUNTARY DISCLOSURE FORM WILL BE FILED SEPARATELY FROM THE EMPLOYMENT APPLICATION.</p>	

Employee Name _____

Date _____

CFR 49 Section 40.25 required Department of Transportation (DOT) regulated companies to check the record of new employees who were previously employed by a DOT regulated employer.

- 1) Have you been employed by any DOT regulated aviation company within the last 24 months prior to the date of your application or transfer to a safety-sensitive position?

Yes _____ No _____

If yes, please provide the name and address of the facility. (If more than one, list the names and addresses on the back of this form.)

- 2) Have you ever tested positive, or refused to test, on any pre-employment drug or alcohol test administered by an employer to which you applied for, but did not obtain, safety-sensitive transportation work covered by DOT agency drug and alcohol testing rules during the past two years?

Yes _____ No _____

Signature

Date

**DISCLOSURE OF INTENT TO OBTAIN CONSUMER REPORT
OR INVESTIGATIVE CONSUMER REPORT**

[COX & COMPANY] may seek background information about you from a consumer reporting agency (“agency”) for employment purposes. The agency will produce this information in a consumer report, an investigative consumer report, or both. [COX & COMPANY] may obtain these reports any time after you authorize [COX & COMPANY] to obtain them. That means [COX & COMPANY] may obtain a report any time during your employment (if [COX & COMPANY] hires you).

A consumer report includes information that bears on your credit standing, character, general reputation, or other personal characteristics. Consumer reports may include credit reports, criminal records, driving records, and other resources.

An investigative consumer report includes similar information. It also includes information from interviews with people who are acquainted with you or who may have relevant information about you.

You can ask [COX & COMPANY] for information about the nature and scope of any investigative consumer report about you that it obtains. You must make your request in writing within a reasonable time after you receive this disclosure.

Date Received

Printed Name

Signature



Mind Your Business, Inc.
 500 Beverly Hanks Ctr, Hendersonville, NC 28792
 Tel: (828) 698-9900 Fax: (828) 698-9918
 Email: mail@mybinc.com

**AUTHORIZATION TO OBTAIN CONSUMER REPORT
 OR INVESTIGATIVE CONSUMER REPORT**

By signing this Authorization, I acknowledge that I have received and read the document titled *Disclosure of Intent to Obtain a Consumer Report or Investigative Consumer Report*, as well as a copy of the document titled *A Summary of Your Rights Under the Fair Credit Reporting Act*.

I authorize [COX & COMPANY] to obtain a consumer report or investigative consumer report about me from **Mind Your Business, Inc. (“MYB”)**. I understand and agree that the information contained in any consumer report MYB provides will be used to determine my eligibility for employment and, if I am hired, my eligibility for continued employment, and that action may be taken by [COX & COMPANY] based on this information.

I further authorize law-enforcement agencies; public and private schools; federal, state, and local agencies and courts; credit bureaus; information bureaus; current and former employers; financial institutions; licensing agencies; the military; and other individuals and entities to provide any information that is requested by MYB or [COX & COMPANY]. This information may include alcohol and controlled-substance information from my previous employers.

To assist [COX & COMPANY] in obtaining a consumer report, I am providing the following information. I understand that providing this information is voluntary; however, without this information, MYB may be unable to properly identify me if it discovers inaccurate information during its background investigation.

I certify that the information that I am providing on this form is true and correct. I understand that any information I provide in an employment application or that I otherwise disclose during my employment may be used to obtain consumer reports and investigative consumer reports.

Full Name (Printed)	First	Middle	Last	Maiden/Other
Signature	Date			

MA, MN, OK, NY, ME, WA, NJ, and CA applicants only: If you want a free copy of the report(s) ordered, check this box .

Complete Residence Address

Street Number/PO Box	Street Name	Apt #
City	State	Zip Code
Date of Birth*	Social Security Number*	
Gender _____	Race _____	

(*You may elect to call MYB directly at (888) 758-3776 with this information)

Driver's License Number _____ State Issued _____

Daytime Telephone Number _____ Email _____

Please list all additional residences that you have resided in during the past 7 years:

Street Number/ PO Box Street Name City State Zip

County

Street Number/ PO Box Street Name City State Zip

County

Street Number/ PO Box Street Name City State Zip

County