

Corinth Coca-Cola Bottling Works, Inc.

Important: Corinth Coca-Cola Bottling Works, Inc. does not discriminate because of race, religion, color, age, disability, sex or national origin. You may be required to take a pre-employment drug screen/substance abuse medical examination as a candidate of employment.

(PLEASE PRINT PLAINLY)

	Date _____
Name (Last, First, Middle) _____	Social Security Number _____
Address _____	
City _____	State _____ Zip _____
Telephone _____	
Have You Ever Been Known By, Or Used Any Other Name [] Yes [] No	What Name _____
Ever Applied For Employment With This Company Before [] No [] Yes	If Yes, Date _____
Are You Applying For [] Full Time [] Part Time [] Temporary [] Summer	Would You Work Only [] 1st Shift [] 2nd Shift [] 3rd Shift
List Any Skills, Training, Experience, Etc. That May Qualify You For The Above Position _____	Rate Of Pay Expected Per Hour Or Week _____
	Date Available To Start _____
List Any Friends And/Or Relatives Employed By This Company	Name _____ Relationship _____
	Name _____ Relationship _____

IDENTIFICATION

GENERAL DATA

If employment is offered, can you submit a birth certificate, social security card, certificate of U. S. citizenship or verification of your legal right to work in the U. S.? _____ Yes _____ No.

If employment is offered, can you produce personal identification such as a U. S. passport, a driver's license or photographic identification card issued by the state? _____ Yes _____ No.

Are you over 18 years of age? _____ Yes _____ No.

Have you ever been convicted of a Felony? _____ Yes _____ No. If "yes" please describe.

U. S. Citizen? _____ Yes _____ No.

MILITARY STATUS

Have you ever served in the U. S. Armed Forces? _____ Yes _____ No.

Describe any special job training received _____

PERSONAL REFERENCES

Name	Occupation	Address	Telephone

(over)

EDUCATION

Grade School (Name)		Highest Grade Completed 5 6 7 8				Graduate <input type="checkbox"/> Yes <input type="checkbox"/> No	
Junior And/Or High School		Grade Pt. Average		1 2 3 4		Graduate <input type="checkbox"/> Yes <input type="checkbox"/> No	
College		Grade Pt. Average		1 2 3 4		Degree	
Major Subject		Minor Subject					
Other Education (Trade School, Graduate Training, Etc.)							

EMPLOYMENT - EXPERIENCE

PRESENT OR LAST EMPLOYER	Name			Address			Telephone
	Date Hired	Date Left	Starting Rate of Pay	Last Rate of Pay	May We Contact <input type="checkbox"/> Yes <input type="checkbox"/> No	Supervisor's Name	
	Type of Work Performed			Reason for Leaving			
2ND LAST EMPLOYER	Name			Address			Telephone
	Date Hired	Date Left	Starting Rate of Pay	Last Rate of Pay	Supervisor's Name		
	Type of Work Performed			Reason for Leaving			
3RD LAST EMPLOYER	Name			Address			Telephone
	Date Hired	Date Left	Starting Rate of Pay	Last Rate of Pay	Supervisor's Name		
	Type of Work Performed			Reason for Leaving			

Except for vacations and holidays, how many work days were you absent during the past calendar year? 0-5 5-10 15-20 + 21 days

PRE-EMPLOYMENT DRUG SCREENING/SUBSTANCE ABUSE CONSENT FORM

I hereby give my voluntary consent to collect from me a blood and/or urine sample and to conduct other necessary medical tests to determine the presence or use of alcohol, drugs or controlled substance. Further, I hereby give my consent for the release of the test results, and other medical information to authorized Company management for appropriate review. I understand that, if I refuse to consent or a positive result from the test may preclude my employment. I hereby release the Company and any employee, agent, physician and/or testing laboratory, its technicians or agents from any and all claims or cause of action as a consequence of my submitting to these tests or the results derived therefrom.

AGREE TO:

Signature

Date

Witness

Date

REFUSED:

Signature

Date

Witness

Date

PRE-EMPLOYMENT POLICY

Corinth Coca-Cola Bottling Works will not knowingly employ any job applicant who uses illegal drugs or is a substance abuser. The company's pre-employment drug screen/substance abuse medical examination shall include urinalysis and/or blood tests to determine use of controlled or illegal substances. Any applicant who refuses to consent to these test(s) or who tests positive for the illegal use of drugs or a controlled substance will not be hired.

INDIVIDUAL DRIVER QUESTIONNAIRE

Name of Insured _____ Policy No. (if assigned) _____

DRIVER'S IDENTIFICATION (Complete as shown on driver's license)

Name of Driver _____ Date of Birth _____

Address _____

	State	License Number	Type or Class	Issue Date*	Expiration Date
CURRENT DRIVER'S LICENSE					

License Restrictions _____ *Show original issue date if license is a renewal

DRIVER'S EXPERIENCE

How long have you had a driver's license? _____ Length of present employment? _____

Number of years driving experience? Private Passenger Cars _____ Buses _____ Cabs _____ Straight Trucks _____ Tractor Trailer Combinations _____

DRIVING RECORD

Has your driver's license ever been suspended or revoked? _____

If so, explain (when, why, and how long): _____

Have you ever been convicted of any traffic violations or convictions? If so, complete the following for each.

	Date	Location	Description*	Type of Vehicle	Fine and/or Penalty
VIOLATIONS OR CONVICTIONS					

*If speeding, show convicted speed and posted speed. For example: 65/55.

Have you ever been involved in any accidents? If so, complete the following for each. Be sure to list all accidents, regardless of who was at fault.

	Date	Location	Description*	Fatality(ies)	Other Injuries	Property Damages**
ACCIDENTS				[] YES [] NO	[] YES [] NO	\$
				[] YES [] NO	[] YES [] NO	\$
				[] YES [] NO	[] YES [] NO	\$

*Show head-on, rear end, upset, intersection, sideswipe, etc. **Include collision damage.

Date _____ Driver's Signature **X** _____

Name and address of agent or broker _____

Name of General Agent _____

1. **ADDITIONAL INFORMATION** (ADD ANY OTHER INFORMATION YOU FEEL PERTINENT. FOR INSTANCE YOU MIGHT SUMMARIZE YOUR OVERALL EXPERIENCE AND RELATE IT TO YOUR CAREER GOALS. USE THIS SECTION TO EXPAND ANY STATEMENTS MADE IN OTHER SECTIONS OF THIS FORM. IDENTIFY THESE BY LETTER.)

DATE	EMPLOYER	POSITION	REASON FOR LEAVING	REMARKS

APPLICANT'S STATEMENT:

I hereby affirm that the information provided is true, accurate, and complete to the best of my knowledge. I also agree that any falsified information or significant omissions may disqualify me from further consideration for employment and may be considered as grounds for dismissal if discovered at a later date.

I authorize a thorough investigation of my past employment activities, agree to cooperate in such investigation, and release from all liability or responsibility all persons and corporations requesting or supplying such information. I further authorize any physician or hospital to release any post-employment information which may be necessary to determine my ability to perform the essential functions of the job in which I am placed.

I hereby agree to submit to any lawful drug testing that may be required as a condition of employment and understand that refusal to submit to such testing may result in my not being considered for employment. I also agree to submit to any post-employment physical examinations that may be required as a condition of continued employment, if hired, and understand that refusal to submit to any such examinations may result in disciplinary action, up to and including discharge.

I understand that my employment is terminable-at-will, that I am not being employed for any specific time, and that this application is not, nor is it intended to be a contract for continued employment or employment.

Our policy is that everyone is subject to a 90 day Training Period or Probationary.

Our Policy is that applications are active for 90 days only. Applicant must submit a new application after this 90 day period.

I acknowledge my understanding that statements which may be contained in policies, practices, handbooks and other company material do not create any guarantee of employment. Any promises to the contrary will only be relied upon by me if they are in writing and signed by an authorized company official.

I understand that the company has the right to modify, amend or terminate policies, practices, benefit plans and other company programs within the limits and requirements imposed by law.

SIGNATURE _____

DATE _____