

<b>APPLICATION FOR EMPLOYMENT</b>	<b>SOLOY AVIATION SOLUTIONS</b> 450 Pat Kennedy Way SW Olympia, WA 98501 Phone: (360) 754-7000 Fax: (360) 943-7659
	Referred by:

**SOLOY AVIATION SOLUTIONS IS AN EQUAL OPPORTUNITY EMPLOYER**

Qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, or the presence of a non-job related medical condition or disability.

<b>PERSONAL INFORMATION</b>		SSN	Application Date:		
Last Name		First Name	Middle Initial	Telephone #	
Present Address	No. & Street	City	State	Zip Code	
Permanent Address	No. & Street	City	State	Zip Code	
Are you a citizen of the United States    ___ Yes    ___ No					
If you are not a citizen of the United States, please indicate your authorization to be employed:					
Military Service Status:			Draft Classification Status:		
<b>EMPLOYMENT DESIRED</b>		Date You Can Start	Salary Desired		
Position(s) Applied For		Are you currently employed?	If so, may we contact your present employer?		
If you have applied to this company before, please indicate where and when:			If you have relatives employed by this company, please give names:		
If you have ever worked for this company before, please indicate when and position held:		Do you seek full or part-time employment?	Shift or hours preferred		
Do you have special skills, experience or qualifications related to the position(s) applied for?			Do you have any physical limitation which would hinder your performance in the position applied for?		
<b>PREVIOUS EMPLOYMENT</b>			Please explain any gap in employment history below.		
Please list most recent employment first		Name and Location	Position	Salary	Reason for Leaving
1	From				Reason For Leaving
	To				
2	From				Reason For Leaving
	To				
3	From				Reason For Leaving
	To:				
4	From				Reason For Leaving
	To				
5	From				Reason For Leaving
	To				

EDUCATIONAL HISTORY		Languages Spoken:		
SCHOOL LEVEL	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DATE GRADUATED	SUBJECTS STUDIED/MAJORS
High School				
College				
Trade, Business, Professional				

BUSINESS REFERENCES			
Name and Address		Telephone	Years Known
1.			
2.			
3.			

PERSONAL REFERNCES		Please list 2 non-relatives whom you have known for at least one year.	
Name and Address		Telephone	Relationship – Years Known
1.			
2.			
3.			

In Case of Emergency Notify:

Name	Address	City	State	Zip Code	Telephone

**NOTICE – DRUG TESTING**

In accordance with Federal Aviation Regulations, all employees who perform designated sensitive safety or security related functions will be subject to: (1) Pre-employment testing; (2) Random testing; (3) Periodic testing; (4) Reasonable cause testing; (5) Post-accident testing; and (6) Return to duty testing.

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time without any previous notice.

Date \_\_\_\_\_ Signature \_\_\_\_\_

The civil rights act of 1964 prohibits discrimination in employment because of race, color, religion, sex or national origin. Some states prohibit discrimination because of age. The age discrimination in employment act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 but less than 65 years of age. If this state prohibits the request of any information on this form, this information will not be used to discriminate against possible employment.

Interviewed by:	DO NOT WRITE BELOW THIS LINE	Interview Date:
NEATNESS		CHARACTER
PERSONALITY		ABILITY
Hired	Dept. Position	Reporting Date
Approved By	Employment Mgr	Dept. Head
		Salary/Wages
		General Mgr

## **AFFIRMATIVE ACTION INFORMATION**

In order to assure equal employment opportunity, Soloy Aviation Solutions, as part of its Affirmative Action Program, requests your voluntary cooperation by filling out this form. Your answers will be treated as confidential. Verification of protected group status may be required.

NAME:	
SOC. SEC. NO.:	DATE OF BIRTH:
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HANDICAPPED: <input type="checkbox"/> YES <input type="checkbox"/> NO
VETERAN: <input type="checkbox"/> YES <input type="checkbox"/> NO DISABLED VETERAN <input type="checkbox"/> YES <input type="checkbox"/> NO	Describe disability <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Sensory
RACE/ETHNIC ORIGIN (CHECK APPROPRIATE ONE)	
<input type="checkbox"/> American Indian	
<input type="checkbox"/> Asian	
<input type="checkbox"/> Black	
<input type="checkbox"/> Caucasian	
<input type="checkbox"/> Hispanic	
<input type="checkbox"/> Other _____	