

# KDM CONSTRUCTION, LLC

1659 COOTERS POINT ROAD  
GILBERT, LOUISIANA 71336

## APPLICATION FOR EMPLOYMENT

Have you ever worked for this company under a different name?  Yes  No

Is any additional information relative to a different name necessary to check work record? If yes, explain.

Name \_\_\_\_\_ SS # \_\_\_\_\_  
Print

Address \_\_\_\_\_  
Street & Apartment # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

How long have you been a resident of this state or city? \_\_\_\_\_

Age \_\_\_\_\_ Are you 18 years old or older?  Is your spouse employed by this employer?

Are you a citizen of the United States? If not a citizen of the United States, do you intend to make application for citizenship?  If not a United States citizen, have you the legal right to remain permanently in the United State?

Last year of education completed \_\_\_\_\_ Drivers License # \_\_\_\_\_ CDL # \_\_\_\_\_

Have you ever been convicted of a crime?  Are there any felony charges pending against you?

Name, address and telephone number of person to be notified in case of accident or emergency

### Previous employment

Company name _____	Worked from _____	to _____
Company name _____	Worked from _____	to _____
Company name _____	Worked from _____	to _____

### Job Skills

I have experience in operating the following pieces of equipment

\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant \_\_\_\_\_ Date of Application \_\_\_\_\_ Employee Receiving Application to be Placed on File

DOH \_\_\_\_\_ DOT \_\_\_\_\_ Reason for Termination \_\_\_\_\_

KDM Construction LLC  
1659 Cooters Point Road  
Gilbert, LA 71336  
318-724-7394

**EMPLOYMENT INFORMATION**  
*(Print Legibly)*

Employee's Name: \_\_\_\_\_ S/S# \_\_\_\_\_  
(Must match Social Security Card exactly)

Mailing Address: \_\_\_\_\_  
Street City State, Zip

Physical Address (if different): \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_

- This is my home phone
- This is my neighbor / friend / family member's phone: \_\_\_\_\_  
(Circle one) (Name)

Date of Birth: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

In case of accident, notify \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_  
Signature of employee  
Date: \_\_\_\_\_



Employee ID: \_\_\_\_\_ Date of Employment: \_\_\_\_\_

- Copy of Social Security Card
- Copy of Driver's License
- Eligibility Verification Form
- Current Federal Tax Withholding Certificate (W4)
- Current State Tax Withholding Certificate (L4)

Termination Date: \_\_\_\_\_ Reason for Termination: \_\_\_\_\_

# Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.**

### Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.		I attest, under penalty of perjury, that I am (check one of the following): <input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A Lawful Permanent Resident (Alien # A _____) <input type="checkbox"/> An alien authorized to work until ___/___/___ (Alien # or Admission #) _____	
Employee's Signature			Date (month/day/year)

**Preparer and/or Translator Certification.** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

### Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): ___/___/___		___/___/___		___/___/___
Document #: _____		_____		_____
Expiration Date (if any): ___/___/___		_____		_____

**CERTIFICATION -** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_/\_\_\_/\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)		

### Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.	
Document Title: _____	Document #: _____ Expiration Date (if any): ___/___/___
I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.	
Signature of Employer or Authorized Representative	Date (month/day/year)

# FEDERAL

Form <b>W-4</b>	<b>Employee's Withholding Allowance Certificate</b>	<b>2004</b>
Print your first name and middle initial	Last name	Your Social Security Number
Home Address (number & street or rural route)	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married but withholding at higher Single rate. Note: If married, but legally separated, check the Single box.	
City or town, state and zip code	If your last name differs from that on your social security card, check here and call 800-772-1213 for a new card..... > <input type="checkbox"/>	
Total number of allowances you are claiming, including yourself..... >		
Additional amount, if any, you want withheld from each paycheck..... >		\$ .
I claim exemption from withholding and I certify that I meet <b>BOTH</b> the following conditions for exemption: <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>ALL</b> Federal income tax withheld because I had <b>NO</b> tax liability and</li> <li>• This year I expect a refund of <b>ALL</b> Federal income tax withheld because I expect to have <b>NO</b> tax liability.</li> </ul> If you meet both conditions, write "Exempt" here..... >		
Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status. <b>Employee's signature</b> (Form is not valid unless you sign it.) >		
		<b>Date &gt;</b>
<b>KDM Construction, L.L.C.</b>		

# FORM L-4

# STATE OF LOUISIANA

Form <b>L-4</b>	<b>Employee's Withholding Allowance Certificate</b>	<b>2004</b>
Print your first name and middle initial	Last name	Your Social Security Number
Home Address (number & street or rural route)	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married but withholding at higher Single rate. Note: If married, but legally separated, check the Single box.	
City or town, state and zip code		
Total number of allowances you are claiming, including yourself.....		
Additional amount, if any, you want withheld from each paycheck.....		\$ .
Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate. (Form is not valid unless you sign it.)		
		<b>Date</b>
<b>KDM Construction, L.L.C.</b>		

## Renewal Community Resident / Employee Certification

### Applicant Information (Please Print)

Last Name	First Name	Middle Name	Birth Date
Social Security #	Telephone #		

### Current Principal Residence

House #	Street Name	City, State	Zip Code

Under Penalties of perjury, I declare that the address that I have given is my principal residence and I will notify my employer of any change in my principle residence.

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Signature of Applicant

KDM Construction, L.L.C.  
1659 Cooters Point Rd  
Gilbert, La. 71336  
318-724-7394 Office  
318-724-7950 Fax

I, \_\_\_\_\_, do hereby give my consent to a pre hire, post  
hire, random and post accident drug test at the direction of any management employee of  
KDM Construction, L.L.C.

Signed \_\_\_\_\_

Date \_\_\_\_\_

# MEDICAL HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PLEASE BE AWARE THAT YOUR ANSWERS WILL NOT AUTOMATICALLY INFLUENCE YOUR EMPLOYMENT STATUS. This information is requested, in part, to identify those employees who may qualify for Louisiana's Second Injury Fund in the event that an injury aggravates a preexisting condition.

Please check in the appropriate space whether or not you or any of your family members currently have or previously have had the following medical conditions:

CHECK EVERY ITEM 'YES' OR 'NO'	YES	NO	CHECK EVERY ITEM 'YES' OR 'NO'	YES	NO
Epilepsy	_____	_____	Diabetes	_____	_____
Loss of use of / amputated foot, arm, hand	_____	_____	Loss of Sight, partial or total	_____	_____
Double vision of blurred sight	_____	_____	High Blood Pressure	_____	_____
Poliomyelitis	_____	_____	Rotator Cuff Injury	_____	_____
Cerebral Palsy	_____	_____	Knee Injury	_____	_____
Multiple Sclerosis	_____	_____	Neck Injury	_____	_____
Parkinson's Disease	_____	_____	Back Injury	_____	_____
Asbestosis	_____	_____	Hypertension	_____	_____
Silicosis	_____	_____	Tuberculosis	_____	_____
Mental Disability	_____	_____	Carpal Tunnel Syndrome	_____	_____
Hemophilia	_____	_____	Mental Retardation	_____	_____
Osteomyelitis	_____	_____	Hodgkin's Disease	_____	_____
Head Injury	_____	_____	Bronchitis	_____	_____
Ankylosis of Joints	_____	_____	Emphysema	_____	_____
Hyperinsulinism	_____	_____	Asthma	_____	_____
Muscular Dystrophy	_____	_____	Compressed Air Sequelae	_____	_____
Arteriosclerosis	_____	_____	Ionizing Radiation Injury	_____	_____
Thrombophlebitis	_____	_____	Nervous Breakdown	_____	_____
Varicose Veins	_____	_____	Dizziness	_____	_____
Heavy Metal Poisoning	_____	_____	Brain Damage	_____	_____
Cardiac disease	_____	_____	Stroke or Cerebral Vascular Accident	_____	_____
Ruptured intervertebral disc	_____	_____	Arthritis	_____	_____
Spinal Fusion or Surgical removal of an intervertebral disc	_____	_____	Any other condition resulting in a partial disability or impairment	_____	_____

*IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE PLEASE EXPLAIN IN DETAIL ON THE BACK OF THIS FORM THE NATURE OF YOUR INJURY OR CONDITION, THE TYPE OF TREATMENT RECEIVED, AND THE NAME, ADDRESS AND PHONE NUMBER OF THE DOCTOR PROVIDING THE TREATMENT*

Has a doctor ever restricted your activities for any condition, work related or otherwise? \_\_\_\_\_ If so please list the medical condition, what kind of restrictions were prescribed, whether these restrictions are temporary or permanent, and whether you are presently under these restrictions.

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Are you presently under any medical treatment by a doctor, psychiatrist or psychologist? \_\_\_\_\_ If so, please list the medical condition being treated, the name of the doctor, his field or specialty, and his address and phone number.

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Are you presently taking medication? \_\_\_\_\_ If so, please list the name of the medication, the medical condition being treated, and the name, address and phone number of the doctor who prescribed the medication:

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