



**M/V BARANOF**

4502 14<sup>th</sup> Ave NW  
Seattle, WA 98107-4618



**M/V COURAGEOUS**

Phone: (206) 545-9501  
Fax: (206) 545-9536

*An Equal Opportunity Employer*

**APPLICATION FOR EMPLOYMENT**

*please print clearly*

Last Name \_\_\_\_\_ Today's Date \_\_\_\_\_

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Social Security No. \_\_\_\_\_

Other names worked under \_\_\_\_\_ Dates \_\_\_\_\_

Current address \_\_\_\_\_ Phone \_\_\_\_\_

City

State

Zip

Permanent address \_\_\_\_\_ Phone \_\_\_\_\_

City

State

Zip

Birth date \_\_\_\_\_ How did you learn of this opening? \_\_\_\_\_

Have you worked for us previously?  Yes  No If Yes, when? \_\_\_\_\_

List any friends or relatives working for us \_\_\_\_\_ Relationship \_\_\_\_\_

Do you have any responsibilities - family, business, or otherwise - which would affect your work?  
 Yes  No If Yes, please explain \_\_\_\_\_

Do you have any physical or mental disabilities or health problems that would affect your work?  
 Yes  No If Yes, please explain \_\_\_\_\_

Are you a U.S. Citizen or do you have a visa permitting you to work in the U.S.?  Yes  No  
Permit No. \_\_\_\_\_ (if applicable) Note: any person hired will be required to complete an I.N.S. Form I-9 (Employment Eligibility Verification)

In an emergency, notify \_\_\_\_\_  
Name Relationship

Address

Phone

U.S. Military Branch \_\_\_\_\_ Dates From: \_\_\_\_\_ To: \_\_\_\_\_

Highest education achieved \_\_\_\_\_  
School Location

Date graduated \_\_\_\_\_ Degree \_\_\_\_\_ Subjects studied \_\_\_\_\_

## WORK HISTORY

Include part time jobs, summer jobs, volunteer jobs. List below current and former employers, beginning with the most recent. You must provide phone numbers of former employers.

List your last 3 employers Name/Address	Nature of work you performed	Employed		Reason for leaving	Immediate Supervisor Name/Title/Phone
		From Mo/Yr	To Mo/Yr		

Are there any other experiences, skills or qualifications which you feel would especially fit you for work with this Company? \_\_\_\_\_

During the past seven years, have you been convicted of, or released from prison for any offense?  
 Yes  No If Yes, please explain: \_\_\_\_\_

(Prior convictions will not necessarily bar applicants from employment.)

### CONDITIONS OF APPLICATION AND EMPLOYMENT:

The above statements and the statements on the following Health Assessment Form are true and accurate. I understand that any misrepresentation or omission of facts called for is cause for my dismissal. I hereby authorize either M/V Baranof or M/V Courageous to investigate any and all statements contained herein, and I authorize and request the persons or firms named above to answer any and all questions relating to this application or any employment based thereon.

I hereby release from all liability M/V Baranof and M/V Courageous, and any person or firm who provides information concerning my prior education, employment, or character. If employed, I understand that my employment is at will and may, regardless of the date my fishing settlement and/or wages are paid, be terminated at any time without prior notice.

I, THE UNDERSIGNED, HAVE CAREFULLY READ AND AGREE TO THE ABOVE CONDITIONS.

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

DO NOT WRITE BELOW THIS LINE

Interviewed By: \_\_\_\_\_ Date Hired: \_\_\_\_\_ Starting Date: \_\_\_\_\_

# M/V Baranof – M/V Courageous

## HEALTH ASSESSMENT

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Position Offered: \_\_\_\_\_

Have you ever been employed by M/V Baranof or M/V Courageous?  Yes  No

If so, when? \_\_\_\_\_

Completed contract?  Yes  No If No, please explain: \_\_\_\_\_

Have you ever had an illness or injury that required you to miss work or school?  Yes  No

If Yes, describe: \_\_\_\_\_

Have you seen a doctor in the past 5 years?  Yes  No

If so, when and reason for visit(s): \_\_\_\_\_

Are you currently receiving medical treatment?  Yes  No

If Yes, describe: \_\_\_\_\_

Are you currently taking medication of any kind?  Yes  No

If Yes, describe: \_\_\_\_\_

Are you allergic to any medications?  Yes  No

If Yes, list: \_\_\_\_\_

Do you have any hobbies?  Yes  No

If Yes, describe: \_\_\_\_\_

What is your usual occupation? \_\_\_\_\_

Yes  No (1) Have you been refused employment or had to leave a job, either temporarily or permanently, because of (circle all the applicable items):

- (a) Sensitivity to chemicals, dust, sunlight, etc.:
- (b) Inability to perform certain motions;
- (c) Other medical reasons. If Yes, give reasons:

Reasons: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (2) Have you had or been advised to have any surgical procedures? If Yes, specify when, where and give details:

\_\_\_\_\_  
\_\_\_\_\_

Yes  No (3) Have you ever been rendered unconscious? If Yes, specify when and describe circumstances:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (4) Have you ever worked with asbestos? If Yes, specify when and describe circumstances:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (5) Have you ever worked at a noisy job? If Yes, specify when and describe circumstances:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (6) Have you ever had any sports injuries? If Yes, explain type of injury, date(s) thereof and treatment received:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (7) Have you ever made claim(s) for unemployment benefits? If Yes, when/where:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (8) Have you ever made claim(s) for maritime or other employment related benefits? If Yes, when/where:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (9) Have you ever been treated at a hospital or hospitalized for any reason whatsoever? If Yes, when and for what reason(s):  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (10) Do you have any physical discomfort when you work in dampness or cold? If Yes, specify when and under what circumstances:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (11) Has your work ever been restricted on account of your health? If Yes, please provide details. (i.e., when, what restrictions):  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (12) Have you ever been injured in a motor vehicle accident? If Yes, specify when and explain circumstances:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (13) Do you have any condition requiring a special work assignment or limitation? If Yes, explain condition and special arrangement or limitation necessary:  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No (14) Do you have any problem which would restrict or make more difficult repetitive lifting or any other heavy physical labor? If Yes, explain in detail:  
\_\_\_\_\_  
\_\_\_\_\_

(15) Are you right handed  or left handed  (Check one)

(16) Date of last dental exam: \_\_\_\_\_

Yes  No (17) Have you ever been a party in a lawsuit? If Yes, specify when and describe the circumstances:  
\_\_\_\_\_  
\_\_\_\_\_

(18) Have you ever been (If answer is Yes, give details in space provided):

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rejected for employment for medical reasons?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rejected for military service for medical reasons?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Discharged from military service for medical reasons?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rejected from an insurance policy for medical reasons?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claimed benefits under workmen's compensation claim?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Exposed to toxic chemicals, vapors, fumes, mists, dusts, radiation or excessive noise? (List specific agents below) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treated for mental condition?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Treated for alcoholism or drug abuse?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you drink? How much? _____   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Accused of sexual harassment?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Convicted of a felony in the last seven years? *  |

**For Men Only:** Do you have:

- |                              |                             |                                  |
|------------------------------|-----------------------------|----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostrate trouble?               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Burning or discharge from penis? |

**For Women Only:**

- |                              |                             |                                      |
|------------------------------|-----------------------------|--------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you pregnant?                    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had abnormal Pap Smear?         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever treated for female disorder?    |
|                              |                             | Date of last menstrual period: _____ |

(19) Provide details for any "Yes" responses in Question (18) above:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(20) Family History. Check any illnesses below which have occurred in parents, brothers, sisters. Indicate to which relative:

- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes _____       | <input type="checkbox"/> Heart disease _____       |
| <input type="checkbox"/> Tuberculosis _____   | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Epilepsy _____       | <input type="checkbox"/> Stroke _____              |
| <input type="checkbox"/> Asthma _____         | <input type="checkbox"/> Cancer _____              |
| <input type="checkbox"/> Kidney disease _____ | <input type="checkbox"/> Blood disease _____       |

\* The fact that you were convicted of a felony does not necessarily preclude you from being considered for this position.

(21) Have you ever had or do you currently have any of the following:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Low blood sugar
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Shooting pains
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Tingling/numbness in any part of body
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Wrist discomfort
<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Wear a brace/support
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Foot problem(s)
<input type="checkbox"/>	<input type="checkbox"/>	Disorder of eyes/ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Date of last tetanus _____
		Last hearing test _____	<input type="checkbox"/>	<input type="checkbox"/>	Skin disease, skin rash or burns
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear hearing protection?	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins or leg pains
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear corrective lenses for vision?	<input type="checkbox"/>	<input type="checkbox"/>	Back problems, complaint, or injury
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Back surgery
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Wear a back brace or back support
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Pain or numbness in legs
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Herniated or ruptured disc
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Neck problem(s)
		Last TB skin test _____ Result _____	<input type="checkbox"/>	<input type="checkbox"/>	Problems of upper or lower extremities
<input type="checkbox"/>	<input type="checkbox"/>	Breathing problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	Knee problem(s)
<input type="checkbox"/>	<input type="checkbox"/>	Can you or have you worked in dust?	<input type="checkbox"/>	<input type="checkbox"/>	Any lumps, pain, numbness or tingling in hands or wrists
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?			Swelling of legs, ankles, hands or wrists
		How many packs per day? _____	<input type="checkbox"/>	<input type="checkbox"/>	Locking fingers
		How long? _____	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis - hand, wrist, elbow, shoulder
<input type="checkbox"/>	<input type="checkbox"/>	Other tobacco products	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis - shoulder/elbow
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Heart problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	Sprains of joints
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint discomfort
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Any broken bones
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur			Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Any stitches
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure			Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	Any disease or disorder of stomach such as stomach ulcers, colitis, hemorrhoids or other intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Pain/pressure in chest
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder problems/surgery	<input type="checkbox"/>	<input type="checkbox"/>	Head injury
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Attempted suicide
<input type="checkbox"/>	<input type="checkbox"/>	Hernia problems/surgery	<input type="checkbox"/>	<input type="checkbox"/>	Mental problems
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Nervous trouble of any sort
<input type="checkbox"/>	<input type="checkbox"/>	Urinary difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Any disease or disorder of the blood
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone(s)	<input type="checkbox"/>	<input type="checkbox"/>	Tested for hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Any surgeries not noted above? List: _____	<input type="checkbox"/>	<input type="checkbox"/>	Tested for HIV
<input type="checkbox"/>	<input type="checkbox"/>	Any medical problems not noted above? List: _____			

Explanation of "Yes" responses: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Yes  No (22) Have you had any illness(es) or injuries other than those already listed?  
 If Yes, explain fully and indicate when you had such illness(es) or injuries:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





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### **NOTICE TO APPLICANTS/EMPLOYEES REGARDING CONSUMER REPORTS**

A consumer report and/or an investigative consumer report including information concerning your character, employment history, general reputation, personal characteristics, policies, record, education, qualifications, motor vehicle record, mode of living, and/or credit and indebtedness may be obtained in connection with your application for and continued employment with the company. A consumer report containing injury and illness records and medical information may be obtained after a tentative offer of employment has been made. Upon timely written request of the Personnel Department of the Company, and within 5 days of the request, the name, address, and phone number of the reporting agency and the nature and scope of the consumer report will be disclosed to you.

Before any adverse action is taken, based in whole or in part on the information contained in the consumer report, you will be provided a copy of the report. The name, address and telephone number of the reporting agency, a summary of your rights under the Fair Credit Reporting Act, as well as additional information on your rights under the law will be included.

### **CONSENT TO OBTAINING CONSUMER REPORTS** **READ CAREFULLY BEFORE SIGNING**

1. I have read the above "Notice to Applicants/Employees Regarding Consumer Reports" and hereby authorize the company to obtain consumer reports and/or investigative consumer reports as described.
2. I understand that I have the right to make a written request within a reasonable amount of time to receive additional, detailed information about the nature and scope of any investigative report or other consumer reports that are made, including the name, address, and telephone number of the consumer reporting agency.
3. I hereby authorize any present or former employers, consumer reporting agencies, educational institutions, criminal justice agencies, departments of motor vehicles, public agency, financial institutions, or any other person or agency having knowledge of me to submit information or opinions about myself, including data received from other sources, in order that my employment qualifications may be evaluated. I hold said persons and/or organizations blameless and without liability for statements or opinions made regarding my character, experience or qualifications.

By my signature below, I acknowledge that I have read and understood all of the above statements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date