

LINDE Corporation

239 GOLF HILL ROAD, P O BOX 1068, HONESDALE, PA 18431

(570) 253-2643

<p style="text-align: center;">AN EQUAL OPPORTUNITY EMPLOYER</p> <p>LINDE CORPORATION DOES NOT DISCRIMINATE IN HIRING OR EMPLOYMENT ON THE BASIS OF RACE, COLOR, RELIGIOUS CREED, NATIONAL ORIGIN, SEX OR ANCESTRY, ON THE BASIS OF ANYONE 40 YEARS OF AGE OR OLDER, DISABILITY OR VIETNAM ERA VETERANS OR DISABLED VETERANS, NOR DO WE DISCRIMINATE PAYMENT OF WAGES TO WOMEN AND MEN PERFORMING SUBSTANTIALLY EQUAL WORK. NO QUESTION ON THIS APPLICATION IS INTENDED TO SECURE INFORMATION TO BE USED FOR SUCH DISCRIMINATION</p>	<p>DATE OF APPLICATION _____</p> <p>POSITION APPLIED FOR _____</p> <p>SALARY EXPECTED _____</p> <p>SOCIAL SECURITY NUMBER _____</p> <p>HOME PHONE NO. _____</p>
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NAME (PLEASE PRINT)			
LAST	FIRST	MIDDLE INITIAL	
PERMANENT ADDRESS			
NO.	STREET	CITY	STATE
			HOW LONG? _____ ZIP _____
PREVIOUS ADDRESS (IF WITHIN THE U.S.)			
NO.	STREET	CITY	STATE
			HOW LONG? _____ ZIP _____
DATE OF BIRTH	AGE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO
ALIEN REGISTRATION NO. _____			
WHAT OTHER NAMES HAVE YOU USED IN PRIOR EMPLOYMENT OR IN SCHOOL? _____ _____			
IN CASE OF EMERGENCY, NOTIFY: NAME			TELEPHONE NO.
ADDRESS		CITY	STATE
			ZIP CODE

On what date would you be able to work? _____

Are you available to work Full-Time Part-Time Shift Work Temporary

Are you on a lay-off and subject to recall? Yes No

Do you have reliable means of transportation to work? Yes No Explain _____

List professional, trade business or civic activities and offices held which may conflict with work schedule. (You may exclude those which indicate race, color, religion, sex, or national origin): _____

Hobbies _____

Any Mechanical Skills _____

Have you ever been convicted of a crime? Yes No If so, list charges, disposition, dates and city:

Give name address and telephone number of three references who are not related to you and are not previous employers and years acquainted:

AFFIRMATIVE ACTION SURVEY

Government agencies require periodic reports on the sex, ethnicity, handicapped and veteran status of applicant. This data is for analysis and affirmative action only. Submission of information is voluntary.

Check One: Male Female

Check One Of The Following: Race/Ethnic Group White Black Hispanic American Indian/ Alaskan Native
 Asian/ Pacific Islander

Check One If Any Of The Following Are Applicable: Vietnam Veteran Disabled Veteran Handicapped Individual

HAVE YOU EVER SERVED IN THE MILITARY SERVICE OF THE UNITED STATES? GIVE DETAILS OF SERVICE						MILITARY SERIAL NO.
DATE OF INDUCTION	BRANCH	RANK INDUCTION DISCHARGE	LIST JOB/ TYPE OF DUTY	TYPE OF DISCHARGE	DATE OF DISCHARGE	TYPE OF RESERVE MEMBERSHIP

HEALTH? <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR	BLOOD TYPE?
DO YOU HAVE ANY KNOWN PHYSICAL IMPAIRMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE LIST DIAGNOSIS, DURATION, RESULTS AND NAME OF PHYSICIAN: _____	
ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST NAME AND ADDRESS OF PHYSICIAN: _____	
WOULD YOU BE WILLING TO TAKE A PHYSICAL EXAMINATION AT OUR EXPENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU MADE ANY WORKMAN'S COMPENSATION CLAIMS WITHIN THE PAST FIVE YEARS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST NATURE, DURATION, NAME OF EMPLOYER, DATES _____	
DID YOU RECEIVE AN AWARD BASED ON PERMANENT DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE OF RELEASE: _____	

NOTE: The sole purpose in inquiring into the applicant's physical condition and health history is to determine whether or not he/she suffers from any physical defect or impairment which could affect ability to perform the job for which he/she is applying.

Any Driving violations in the past 3 years? Yes No If Yes, why _____
Class of License _____

Do you have any physical defects which preclude you from performing certain kinds of work? _____ if yes, describe such defects and specific work limitations _____

Have you had a major illness in the past 5 years? _____ If yes, describe _____
 Have you received compensation for injuries? _____ If yes, describe _____

SPECIAL QUESTIONS

DO NOT ANSWER ANY OF THE QUESTIONS IN THIS FRAMED AREA UNLESS THE EMPLOYER HAS **CHECKED A BOX PRECEDING** A QUESTION, THEREBY INDICATING THAT THE INFORMATION IS REQUIRED FOR A BONA FIDE OCCUPATIONAL QUALIFICATION, OR DICTATED BY NATIONAL SECURITY LAWS, OR IS NEEDED FOR OTHER LEGALLY PERMISSIBLE REASONS.

- HEIGHT _____ FEET _____ INCHES CITIZEN OF U.S. _____ YES _____ NO
 WEIGHT _____ lbs. DATE OF BIRTH * _____
 WHAT FOREIGN LANGUAGES DO YOU SPEAK
 FLUENTLY? _____ READ _____ WRITE _____

* 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 70 years of age.

	ELEMENTARY					HIGH				COLLEGE/UNIVERSITY				GRADUATE/PROFESSION			
SCHOOL NAME																	
YEARS COMPLETED: (Circle)	4	5	6	7	8	9	10	11	12	1	2	3	4	1	2	3	4
DIPLOMA/DEGREE																	
DESCRIBE COURSE OF STUDY																	

SPECIAL SKILLS AND TRAINING

Please describe any skills or training you possess that you feel help qualify you for the position for which you have applied. Also, list any equipment (office or industrial) that you have experience operating.

List below all present and past employment, beginning with your most recent

I	Name and Address of Company and Type of Business	From		To		Describe the work you did	Weekly Starting Salary	Weekly Last Salary	Reason for Leaving	Name of Supervisor
		Mo.	Yr.	Mo.	Yr.					
	Telephone:									

II	Name and Address of Company and Type of Business	From		To		Describe the work you did	Weekly Starting Salary	Weekly Last Salary	Reason for Leaving	Name of Supervisor
		Mo.	Yr.	Mo.	Yr.					
	Telephone:									

III	Name and Address of Company and Type of Business	From		To		Describe the work you did	Weekly Starting Salary	Weekly Last Salary	Reason for Leaving	Name of Supervisor
		Mo.	Yr.	Mo.	Yr.					
	Telephone:									

IV	Name and Address of Company and Type of Business	From		To		Describe the work you did	Weekly Starting Salary	Weekly Last Salary	Reason for Leaving	Name of Supervisor
		Mo.	Yr.	Mo.	Yr.					
	Telephone:									

I hereby give permission to contact the employers listed above concerning any information you deem relevant. SIGNED _____
 If there is a particular employer(s), you do not wish us to contact, please indicate which one(s). _____

APPLICANT'S STATEMENT

I CERTIFY THAT ANSWERS GIVEN HERIN ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION FOR EMPLOYMENT AS MAY BE NECESSARY IN ARRIVING AT AN EMPLOYMENT DECISION. I UNDERSTAND THAT THIS APPLICATION IS NOT AND IS NOT INTENDED TO BE A CONTRACT OF EMPLOYMENT.

IN THE EVENT OF EMPLOYMENT, I UNDERSTAND THAT FALSE OR MISLEADING INFORMATION GIVEN IN MY APPLICATION OR INTERVIEW(S) MAY RESULT IN DISCHARGE. I UNDERSTAND, ALSO, THAT I AM REQUIRED TO ABIDE BY ALL RULES AND REGULATIONS OF THE COMPANY.

SIGNATURE OF APPLICANT

DATE

**BACKGROUND SCREEN
RELEASE OF INFORMATION**

All information supplied to Linde Corporation in this application is subject to verification.

As a condition of employment a background screen will be conducted on all prospective employees. This screening process includes legal, employment, unemployment, school and educational records, vocational training or rehabilitation records.

I have read or had this statement explained to me and fully understand its content.

I hereby empower any institution or agency to release to Linde Corporation any and all information requested by Linde Corporation concerning my background.

Prospective Employee Signature

Equal Opportunity Employer

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, authorize the release of any
(Employee Name)
information including the diagnosis of any treatment or examination rendered to me during my employment with Linde Corporation with regard to any Workers' Compensation Claim to Linde Corporation

(Signature)

(Date)

CONSENT FORM: DRUG TESTING

I understand and agree that I may be asked to undergo a medical examination prior to being hired which will include a substance abuse test. I understand that if I refuse to sign this consent to the examination and/or test, my application will not be considered further. If the test is positive, I understand that it will be followed by a confirmation test of the same blood and/or urine sample by an alternative chemical method. If the second test is also positive, I understand that my application will not be considered further. An exception will be made for the use of legally prescribed medications taken under the directions of a physician. I have taken the following drugs within the last 96 hours:

(Identify name and amount)

(If "none", so indicate)

I hereby consent to the medical examination including the substance abuse test.

Date: _____

Signed: _____

Witness: _____

AT WILL FORM

I understand that employment with Linde Corporation is strictly at will and that any changes in this policy may be affected only by a written agreement signed by the company president. I do agree to the fact that I may be discharged at any time at Management's discretion. I understand that this application for employment is not a contract.

Date: _____

Prospective Employee Signature

Witness

Equal Opportunity Employer

