



# APPLICATION FOR EMPLOYMENT

**ROUNDS CONSTRUCTION  
COMPANY, INC.**

1124 34<sup>th</sup> Ave

Brookings, SD 57006

Phone: (605) 693-4000 Fax: (605) 693-5811

**ROUNDS CONSTRUCTION**  
COMPANY

**Date of Application:** \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First Middle

**Mailing Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Drivers License #:** \_\_\_\_\_ **CDL Rating:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_  
Name Phone Relationship

**Position Desired:** \_\_\_\_\_

**Desired Wage:** \_\_\_\_\_ **When can you start:** \_\_\_\_\_

**Have you had a Physical Examination in the past 5 years?**  Yes  No **Year:** \_\_\_\_\_

**Reason for exam:** \_\_\_\_\_

**To your knowledge, do you have any of the following:**

- |                   |  |                      |  |
|-------------------|--|----------------------|--|
| Rupture, hernia   | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Defective sight   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Defective hearing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney ailments   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Injury       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Skin Eruptions    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Narcolepsy(sleeping) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Will you abide by the safety rules of this company?**  Yes  No

**If injured on the job, will you immediately report it to your superintendent and accept medical facilities recommended by your employer?**  Yes  No

**Employment History:**

Company Name: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ Starting Wage: \_\_\_\_\_ Ending Wage: \_\_\_\_\_

Job Responsibilities: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

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Company Name: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ Starting Wage: \_\_\_\_\_ Ending Wage: \_\_\_\_\_

Job Responsibilities: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

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Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ Starting Wage: \_\_\_\_\_ Ending Wage: \_\_\_\_\_

Job Responsibilities: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

In addition to your work history please list your other skills or experience we should consider:

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

**To be considered for employment ALL items MUST be completed**

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

Signature of Superintendent/Company Rep: \_\_\_\_\_