

**EMPLOYMENT APPLICATION**



State of North Carolina  
**NOTE: Apply to the department listed on posting**

An Equal Opportunity Employer, North Carolina - State Government  
<http://www.oshr.nc.gov/jobs/index.html> (<http://www.oshr.nc.gov/jobs/index.html>)

**Received:**  
**For Official Use Only:**  
 QUAL: \_\_\_\_\_  
 DNQ: \_\_\_\_\_  
 Experience  
 Training  
 Other: \_\_\_\_\_

**PERSONAL INFORMATION**

<b>POSITION TITLE:</b>		<b>Job Number:</b>	
<b>NAME:</b> (Last, First, Middle)		<b>Last Four Digits of Social Security Number:</b>	
<b>Former Last Name (if applicable):</b>		<b>Date And Month of Birth:</b>	
<b>ADDRESS:</b> (Street, City, State/Province, Zip Code)			
<b>HOME PHONE:</b>		<b>ALTERNATE PHONE:</b>	
<b>EMAIL ADDRESS:</b>			
<b>DRIVER'S LICENSE:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>DRIVER'S LICENSE:</b> State/Province: Number:	<b>DRIVER'S LICENSE:</b> Class:	<b>LEGAL RIGHT TO WORK IN THE UNITED STATES?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**PREFERENCES**

<b>WHAT IS YOUR MINIMUM COMPENSATION REQUIREMENT?</b>	<b>ARE YOU WILLING TO RELOCATE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
<b>SHIFTS YOU WILL ACCEPT: Please check all that apply.</b> <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Rotating <input type="checkbox"/> Weekends <input type="checkbox"/> On Call (as needed)	
<b>WHAT TYPE OF JOB ARE YOU LOOKING FOR? Please check all that apply.</b> <input type="checkbox"/> Regular <input type="checkbox"/> Temporary	
<b>TYPES OF WORK YOU WILL ACCEPT: Please check all that apply.</b> <input type="checkbox"/> Permanent Full Time <input type="checkbox"/> Permanent Part Time <input type="checkbox"/> Temporary Full Time <input type="checkbox"/> Temporary Part Time	
<b>OBJECTIVE:</b>	

**EDUCATION**

<b>SCHOOL NAME:</b>	<b>SCHOOL TYPE:</b>	<b>DATES:</b>
<b>LOCATION:</b> (City, State/Province)	<b>DID YOU GRADUATE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>DEGREE RECEIVED:</b>
<b>MAJOR:</b>	<b>UNITS COMPLETED:</b>	
<b>WEBSITE:</b>	<b>UNIT TYPE:</b>	

**WORK EXPERIENCE**

<b>DATES:</b>	<b>EMPLOYER:</b>	<b>POSITION TITLE:</b>
<b>ADDRESS:</b> (Street, City, State/Province, Zip Code)		<b>COMPANY URL:</b>
<b>PHONE NUMBER:</b>	<b>SUPERVISOR:</b>	<b>MAY WE CONTACT THIS EMPLOYER?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HOURS PER WEEK:</b>	<b># OF EMPLOYEES SUPERVISED:</b>	

DUTIES:		
REASON FOR LEAVING:		

DATES:	EMPLOYER:	POSITION TITLE:
ADDRESS: (Street, City, State/Province, Zip Code)		COMPANY URL:
PHONE NUMBER:	SUPERVISOR:	MAY WE CONTACT THIS EMPLOYER? <input type="checkbox"/> Yes <input type="checkbox"/> No
HOURS PER WEEK:	# OF EMPLOYEES SUPERVISED:	
DUTIES:		
REASON FOR LEAVING:		

DATES:	EMPLOYER:	POSITION TITLE:
ADDRESS: (Street, City, State/Province, Zip Code)		COMPANY URL:
PHONE NUMBER:	SUPERVISOR:	MAY WE CONTACT THIS EMPLOYER? <input type="checkbox"/> Yes <input type="checkbox"/> No
HOURS PER WEEK:	# OF EMPLOYEES SUPERVISED:	
DUTIES:		
REASON FOR LEAVING:		

<b>CERTIFICATES AND LICENSES</b>	
TYPE:	
LICENSE NUMBER:	ISSUING AGENCY:

<b>SKILLS</b>	
OFFICE SKILLS:	

<b>OTHER SKILLS:</b>
<b>LANGUAGE(S):</b>

<b>REFERENCES</b>		
<b>REFERENCE TYPE:</b>	<b>NAME:</b>	<b>POSITION:</b>
<b>ADDRESS:</b> (Street, City, State/Province, Zip Code)		
<b>EMAIL ADDRESS:</b>	<b>PHONE NUMBER:</b>	

<b>REFERENCE TYPE:</b>	<b>NAME:</b>	<b>POSITION:</b>
<b>ADDRESS:</b> (Street, City, State/Province, Zip Code)		
<b>EMAIL ADDRESS:</b>	<b>PHONE NUMBER:</b>	

<b>REFERENCE TYPE:</b>	<b>NAME:</b>	<b>POSITION:</b>
<b>ADDRESS:</b> (Street, City, State/Province, Zip Code)		
<b>EMAIL ADDRESS:</b>	<b>PHONE NUMBER:</b>	

**Agency - Wide Questions**

1. Please provide the last 4 digits of your Social Security Number \_\_\_\_\_
2. Are you currently employed by the State of North Carolina?  
 Yes  No
3. If you answered "yes" to the previous question, please indicate the agency/university where you are currently working.  
 \_\_\_\_\_
4. Are you related by blood or marriage to any person now working for the State?  
 Yes  No
5. If you answered "yes" to the previous question, please provide their name, relationship to you, and the agency where employed.  
 \_\_\_\_\_
6. Are you a layoff candidate with the State of North Carolina eligible for RIF priority reemployment consideration as described by GS 126?  
 Yes  No
7. If you answered "yes" to the previous question, please indicate your date of written notification \_\_\_\_\_
8. Will you consider employment anywhere in North Carolina?  
 Yes  No
9. If you selected "no" to the previous question, please list the counties where you would be willing to work.  
 \_\_\_\_\_
10. Are you the spouse of an active-duty service member or the spouse of a North Carolina National Guard member?  
 Yes  No

**11. Where did you learn about this opportunity?**

- OSHR website
- Agency website
- Professional Association Website
- Professional Association
- Professional Journal
- Friend/Colleague
- Social Media
- TV/Radio
- Employment Security Commission
- State of NC Career Expo
- Career Fair for Persons with Disabilities
- Military Event
- Other

**12. Have you served honorably in the Armed Forces of the United States on active duty for reasons other than training?**

- Yes  No

**13. Do you wish to declare eligibility for Veterans Preference? If yes, please attach a copy of the DD-214. (If you answered "N/A" to the military service question, you do not need to answer this question.)**

- Yes  No

**14. Do you wish to declare a service-connected disability? (If you answered "N/A" to the military service question, you do not need to answer this question.)**

- Yes  No

**15. Do you wish to declare eligibility for veterans' preference as the surviving spouse or dependent of a deceased veteran who died for service-related reasons?**

- Yes  No

**16. Do you wish to declare eligibility for veterans' preference as the spouse of a disabled veteran?**

- Yes  No

**17. Please provide the entry and separation dates of your (or spouse's) qualifying active military service, branch of service, and rank.**

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**18. If subject to Military Selective Service registration, certify compliance by indicating below.**

- Subject to Military Selective Service and have complied
- Subject to Military Selective Service and have not complied
- Not subject to Military Selective Service Registration

**19. Do you wish to declare eligibility for National Guard preference?**

- Yes  No

**20. Are you a resident of North Carolina who is a current member in good standing of either the North Carolina Army National Guard or the North Carolina Air National Guard? If yes, please attach a copy of the NGB 23A (RPAS)**

- Yes  No

**21. Are you a resident of North Carolina who is a former member of either the North Carolina Army National Guard or the North Carolina Air National Guard, who discharge is under honorable conditions with a minimum of six years of creditable services? If yes, please attach a copy of the DD256 or NGB 22.**

- Yes  No

**22. Do you wish to declare eligibility for veterans' preference as the surviving spouse or dependent of a member of the North Carolina Army National Guard or the North Carolina Air National Guard who died on State active duty either directly or indirectly as a result of that service?**

- Yes  No

**23. Do you wish to declare eligibility for veterans' preference as the surviving spouse or dependent of a member of the North Carolina National Guard who died for service-related reasons during peacetime?**

- Yes  No

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By signing below, I certify that I have given true, accurate and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigation of all statements made in this application and understand that false information or documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action or dismissal if I am employed, and(or) criminal action. I further understand that dismissal upon employment shall be mandatory if fraudulent disclosures are given to meet position qualifications (Authority: GS 126-30, GS 14-122.1). I also understand that it is my responsibility to update my contact information should there be any changes in my name, address, phone number, or e-mail address.

This application was submitted by:

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

## Equal Opportunity Information

State Government policy prohibits discrimination based on race, sex, color, creed, national origin, age, genetic information, or disability. Sex, age, or absence of disability is a bona fide occupational qualification in a small number of State jobs. The information requested below will not affect you as an applicant and is not forwarded to the hiring manager. Its sole use will be to see how well our recruitment efforts are reaching all segments of the population. Answering the ethnicity question is optional. Birth date is required for correct input by our technicians of paper application content into our electronic application system, where birthdate is required in order to save the application.

This information will not be forwarded to the hiring manager

**1. What is your gender**

- Male  Female

**2. What is your ethnicity?**

- White (Non-Hispanic/Latino)  
 Black or African American (Non-Hispanic/Latino)  
 Asian  
 American Indian or Alaskan Native  
 Native Hawaiian or Other Pacific Islander  
 Two or More Races (Non-Hispanic/Latino)

**3. What is your date of birth? (xx/xx/xxxx) \_\_\_\_\_**

**4. What is your age range?**

- Less than 20  
 20-29  
 30-39  
 40-49  
 50-59  
 60-69  
 70 or greater

# Voluntary Self-Identification of Disability

Form CC-305  
Page 1 of 1

OMB Control Number 1250-0005  
Expires 05/31/2023

Name: \_\_\_\_\_  
Employee ID: \_\_\_\_\_  
(If applicable)

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

## Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunities to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

## How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

## Please check one of the boxes below:

- Yes, I Have a Disability, or have a History/Record of Having a Disability
- No, I Don't Have a Disability, or a History/Record of Having a Disability
- I Don't Wish to Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

## For Employer Use Only

*Employers may modify this section of the form as needed for recordkeeping purposes.*

*For example:*

Job Title: \_\_\_\_\_ Date of Hire: \_\_\_\_\_