

**PLANT IT HAWAII, INC.**

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

FULL NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SEX: M F BIRTHDATE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ PREGNANT: \_\_\_\_\_

NUMBER OF CHILDREN RESPONSIBLE FOR: \_\_\_\_\_ NAMES & AGES: \_\_\_\_\_

DO YOU HAVE MEDICAL INSURANCE: \_\_\_\_\_ IF YES, WITH WHOM: \_\_\_\_\_

HAVE YOU BEEN TREATED FOR A MEDICAL CONDITION OR BACK OR OTHER INJURY IN THE LAST TEN YEARS? \_\_\_\_\_

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

\_\_\_\_\_ ARE YOU COLOR BLIND: \_\_\_\_\_

LIST EDUCATIONAL HISTORY: \_\_\_\_\_

LIST YOUR LAST THREE PLACES OF EMPLOYMENT, NAME OF EMPLOYER, ADDRESS, PHONE NUMBER, DATES OR EMPLOYMENT AND REASON FOR LEAVING, STARTING PAY AND ENDING PAY:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

LIST YOUR PERSONAL QUALITIES, SKILLS, AND PAST EXPERIENCES THAT WILL HELP YOU SUCCEED:

DO YOU SMOKE: \_\_\_\_\_ ARE YOU WILLING TO TAKE A DRUG TEST: \_\_\_\_\_

DAYS AND TIMES YOU ARE ABLE AND WILLING TO WORK: \_\_\_\_\_

DESIRED STARTING PAY: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_