APPLICATION FOR EMPLOYMENT

(PRE-EMPLOYMENT QUESTIONNAIRE) (AN EQUAL OPPORTUNITY EMPLOYER)

PERSONAL INFORMATION

DATE _____

NAME _____ SOCIAL SECURITY NUMBER _____
LAST FIRST MIDDLE

MAILING ADDRESS _____
STREET CITY STATE ZIP

PHYSICAL ADDRESS _____
STREET CITY STATE ZIP

PHONE NO. _____ ARE YOU 18 YEARS OR OLDER? YES NO

DRIVERS LICENSE STATE & NUMBER: _____

ARE YOU PREVENTED FROM LAWFULLY BECOMING EMPLOYED IN THIS COUNTRY BECAUSE OF VISA OR IMMIGRATION STATUS? YES _____ NO _____

EMPLOYMENT DESIRED

POSITION _____ DATE YOU CAN START _____ SALARY DESIRED _____

ARE YOU EMPLOYED NOW? _____ IF SO, CAN WE INQUIRE OF YOUR PRESENT EMPLOYER? _____

EVER APPLIED TO THIS COMPANY BEFORE? _____ WHERE? _____ WHEN? _____

REFERRED BY: _____

EDUCATION	NAME & LOCATION OF SCHOOL	*NO. OF YEARS ATTENDED	*DID YOU GRADUATE	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPON-DENCE SCHOOL				

GENERAL

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK _____

SPECIAL SKILLS _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? _____ IF YES EXPLAIN: _____

CONVICTED WHEN & WHERE? _____

EXCLUDE ORGANIZATIONS, THE NAME OF WHICH INDICATES THE RACE, CREED, SEX, AGE, MARITAL STATUS, COLOR OR NATION OF ORIGIN OF ITS MEMBERS

U.S. MILITARY OR NAVAL SERVICE _____ RANK _____ PRESENT MEMBERSHIP IN NATIONAL GUARD OR RESERVES _____

*This form has been revised to comply with the provision of the Americans with Disabilities Act and the final regulations and interpretive guidance promulgated by the EEOC on July 26, 1991.

(CONTINUED ON OTHER SIDE)

FORMER EMPLOYERS (LIST BELOW LAST THREE EMPLOYERS, STARTING WITH LAST ONE FIRST).

DATE MONTH & YEAR	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM TO				
FROM TO				
FROM TO				
FROM TO				

WHICH OF THESE JOBS DID YOU LIKE BEST? _____

WHAT DID YOU LIKE MOST ABOUT THIS JOB? _____

REFERENCES: GIVE THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS	BUSINESS	YEARS ACQUAINTED
1.			
2.			
3.			

THE FOLLOWING STATEMENT APPLIES IN: MARYLAND & MASSACHUSETTS. (Fill in name of state).
IT IS UNLAWFUL IN THE STATE OF _____ TO REQUIRE OR ADMINISTER A LIE DETECTOR TEST AS A CONDITION OF EMPLOYMENT OR CONTINUED EMPLOYMENT. AN EMPLOYER WHO VIOLATES THIS LAW SHALL BE SUBJECT TO CRIMINAL PENALTIES AND CIVIL LIABILITY.

SIGNATURE OF APPLICANT _____

IN CASE OF EMERGENCY
NOTIFY: _____
NAME ADDRESS PHONE NO.

"I CERTIFY THAT ALL THE INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE AND COMPLETE, AND I UNDERSTAND THAT IF ANY FALSE INFORMATION, OMISSIONS, OR MISREPRESENTATIONS ARE DISCOVERED, MY APPLICATION MAY BE REJECTED AND, IF I AM EMPLOYED, MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME.
IN CONSIDERATION OF MY EMPLOYMENT, I AGREE TO CONFORM TO THE COMPANY'S RULES AND REGULATIONS, AND I AGREE THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME, AT EITHER MY OR THE COMPANY'S OPTION. I ALSO UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS OF MY EMPLOYMENT MAY BE CHANGED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME BY THE COMPANY. I UNDERSTAND THAT NO COMPANY REPRESENTATIVE , OTHER THAN IT'S PRESIDENT, AND THEN ONLY WHEN IN WRITING AND SIGNED BY THE PRESIDENT, HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIC PERIOD OF TIME, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING."

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY _____ DATE _____
REMARKS: _____

NEATNESS _____ ABILITY _____
HIRED: YES NO POSITION _____ DEPARTMENT _____
SALARY/WAGE _____ DATE REPORTING TO WORK _____
APPROVED: 1. _____ 2. _____ 3. _____
EMPLOYMENT MANAGER DEPT. HEAD GENERAL MANAGER

NOTICE TO APPLICANTS/EMPLOYEES REGARDING CONSUMER REPORTS

A consumer report and/or an investigation consumer report including information concerning your character, employment history, general reputation, personal characteristics, police record, education, qualifications, motor vehicle record, mode of living and/or credit with 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 numbers 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 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.

CONSENT TO OBTAINING CONSUMER REPORTS READ BEFORE SIGNING

1) I HAVE READ THE "NOTICE TO APPLICANTS/EMPLOYEES REGARDING CONSUMBER REPORTS" AND HEREBY AUTHORIZE THE COMPANY TO OBTAIN CONSUMER REPORTS AND/OR INVESTIGATE CONSUMER REPORTS AS DESCRIBED. 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.

2) I HEREBY AUTHORIZE ANY PRESENT OR FORMER EMPLOYERS, CONSUMBER 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 DATE 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 ACKNOWLEGE THAT I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE STATEMENTS.

_____ _____

PRINT NAME SIGNATURE

_____

DATE

REQUEST FOR INFORMATION FROM PREVIOUS EMPLOYER

I hereby authorize you to release the following information to ***Guichard Operating Company, LLC*** for purposes of investigation. You are released from any and all liability which may result from furnishing such information.

_____ Date

_____ Applicant's Signature

Dear Sir or Madam:

The below named individual has made application to this company for a position as _____ and states that he/she was employed by you as _____ from _____ to _____. We appreciate your time in completing, in confidence, the information requested below.

Sincerely,

Guichard Operating Company, LLC
Safety Coordinator

Request for Information From Previous Employer

(DO NOT FILL OUT – For Office Use Only)

Name of Applicant: _____ Social Security No. _____

1. Employed from _____ to _____ as _____
at wage or salary of _____ per _____.

2. Was he/she a safe and efficient worker? _____

3. Reason for leaving your employ: _____
_____

4. Was his/her general conduct satisfactory? _____

5. Has he/she ever failed a drug or alcohol test or refused a drug or alcohol test in the last 2 years? _____

CONFIDENTIAL REPORT OF PERSONAL REFERENCE

Please indicate your opinion by placing a check in the appropriate column.

Characteristics	Excellent	Good	Fair	Poor
Disposition, tact, ability to get along with others				
Initiative, resourcefulness				
Safety habits				
Driving skill				
Attitude				
Loyalty				

Any other remarks _____
_____
_____
_____
_____
_____

Signature _____ Title _____

Date _____

GUICHARD OPERATING COMPANY, L.L.C.
P.O. BOX 2000 CROWLEY, LA 70527-2000

PAYROLL POLICY

The process at which GUICHARD OPERATING COMPANY, LLC pays their rig employees is as follows: *Weekly pay checks* are **MAILED** to your choice of address every Friday; *Expense checks* can be mailed or picked up at the office by the employee ***ONLY***; *Safety Bonus checks* are **MAILED** to you - **ONLY IF YOUR CREW HAS NOT HAD ANY ACCIDENTS THAT MONTH AND YOU HAVE WORKED THE FULL MONTH WITHOUT CEASING EMPLOYMENT.**

I have read and understand the paragraph above.

_____
Employees Signature

_____
Date

Revised 2/16

(337) 334-8301 drilling@guichardco.com www.guichardoperating.com 1-800-738-4645

GUICHARD OPERATING COMPANY, L.L.C.
P.O. BOX 2000 CROWLEY, LA 70527-2000

DRUG FREE WORKPLACE

Guichard Operating Co., LLC is vitally concerned in the safety and health of its everyone. It is the express policy of Guichard Operating Co., LLC that when anyone comes to work, they are expected to be lucid, sober and prepared to perform their job functions without endangering themselves or their co-workers because of drug or alcohol use on or off the job site.

Any person who is taking prescribed medication or non-prescribed drugs, which may impair their ability to perform their job functions, must immediately notify their supervisor. Everyone is subject to drug and alcohol testing at any time, including pre-employment, but especially after an accident. Anyone found to be using prescribed or non-prescribed drugs, which may impair their performance without notifying their supervisor, or found to be intoxicated will be subject to immediate termination. In addition, anyone failing a pre-employment drug screen will be obligated to pay for such testing and subject to immediate termination.

WARNING: PURSUANT TO LSA-RS 23:1081, ANYONE FOUND TO BE UNDER THE INFLUENCE OF ALCOHOL OR ANY NON-PRESCRIBED CONTROLLED DANGEROUS SUBSTANCES WILL BE SUBJECT TO IMMEDIATE TERMINATION AND MAY FORFEIT ANY RIGHTS THEY MAY HAVE OTHERWISE HAD TO WORKERS' COMPENSATION AND UNEMPLOYMENT COMPENSATION. LSA-RS 23:897, GIVES GOC THE RIGHT TO COLLECT THE COST OF A COMPANY PAID PREEMPLOYMENT DRUG TEST FROM EMPLOYEES THAT TERMINATE THEIR EMPLOYMENT RELATIONSHIP SOONER THAN NINETY WORKING DAYS AFTER THEIR FIRST DAY OF WORK.

I have read and understood the paragraphs above.

_____
Employee's Signature

_____
Date

Revised 2/16

(337) 334-8301 drilling@guichardco.com www.guichardoperating.com 1-800-738-4645

R-1300 (4/11)

LDR
Contributing to a better quality of life

Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse, and check "*No exemptions or dependents claimed*" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "*Single*" under number 3 below. if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "Single" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "Married" under number 3 below.

A.

Block B

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

B.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
Louisiana Department of Revenue

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial	Last name
2. Social Security Number	3. Select one ☐ No exemptions or dependents claimed ☐ Single ☐ Married
4. Home address (number and street or rural route)	
5. City / State / ZIP	
6. Total number of exemptions claimed in Block A	6.
7. Total number of dependents claimed in Block B	7.
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.	8.

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date

The following is to be completed by employer.

9. Employer's name and address	10. Employer's state withholding account number

Form **W-4** (Rev. December 2020)
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
▶ Give Form W-4 to your employer.
▶ Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.) ▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

GUICHARD OPERATING COMPANY, L.L.C.
P.O. BOX 2000 CROWLEY, LA 70527-2000

EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE LETTER

We are committed to providing Workers' Compensation benefits to all employees who sustain an employment-related injury in accordance with Louisiana law.

If a work-related injury or disability is caused, or made worse, by a "pre-existing" condition, ***Guichard Operating Company, LLC*** may be able to seek partial reimbursement of the benefit dollars paid to you, or on your behalf, from the Louisiana Second Injury Fund. Such reimbursement would be made to ***Guichard Operating Company, LLC*** without a reduction in benefits to you.

In order for ***Guichard Operating Company, LLC*** to be considered for reimbursement from the Second Injury Fund, it has to show that it knowingly hired or knowingly retained the employee with a pre-existing disability. To establish this fact, ***Guichard Operating Company, LLC*** requires all employees to complete the attached questionnaire.

All questions must be answered. If the answer is "NO" or "NONE", please indicate. All responses must be complete. If a response requires explanation, please provide one. If there is not enough space on the form for a complete response, please complete your response on the back of the form.

The information obtained from the questionnaire will be kept **CONFIDENTIAL** and will not be made part of your personnel file. As you complete the attached questionnaire, you should be aware that:

FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

I have read the foregoing notice and have completed the attached questionnaire to the best of my knowledge, information and belief.

_____ Signature

_____ Date

(337) 334-8301
drilling@guichardco.com
www.guichardoperating.com
1-800-738-4645

SECOND INJURY FUND • Employee Medical History Questionnaire

Please answer the following questions by circling either YES or NO.

FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

1. Have you ever had a disease or disability arising from your occupation? YES NO
   If YES, please explain: _____
2. Have you ever received workers' compensation benefits for an injury that occurred at work? YES NO
   If YES, when? _____
   How long were you on compensation? _____
   Name of employer: _____
   Nature of injury: _____
3. Have you ever been rejected for employment, insurance, or military service because of your health? YES NO
   If YES, please explain: _____
4. Have you ever had back trouble or injury to your back, head or neck? YES NO
   If YES, please explain: _____
5. Do you have any restrictions or limitations upon your physical activities? YES NO
   If YES, please explain: _____
6. What operations, accidents, broken bones, strains or serious illnesses have you had?

Have you had any of the following? Put an "X" in the appropriate box. Each illness/injury requires a YES (Y) or NO (N) response.

Y	N		Y	N		Y	N		Y	N	
☐	☐	Amputation (foot, leg, arm, hand or total loss thereof)	☐	☐	Communicable Disease	☐	☐	Ionizing Radiation Injury	☐	☐	Reflex Sympathetic Dystrophy
☐	☐	Ankylosis of Joints	☐	☐	Compressed Air Sequelae	☐	☐	Kidney Disorder	☐	☐	Repetitive Motion Injury
☐	☐	Arteriosclerosis	☐	☐	Diabetes	☐	☐	Loss of Hearing (more than 75%)	☐	☐	Residual Disability from Polio
☐	☐	Arthritis	☐	☐	Dizziness	☐	☐	Loss of Sight (of one or both eyes or a partial loss of uncorrected vision)	☐	☐	Rheumatism
☐	☐	Asthma	☐	☐	Double Vision (Blurred Sight)	☐	☐	Loss of Use of Limbs	☐	☐	Rotator Cuff Injury
☐	☐	Back/Neck Problem	☐	☐	Emphysema	☐	☐	Mental Disorders	☐	☐	Ruptured Intervertebral Disc
☐	☐	Brain Damage	☐	☐	Epilepsy	☐	☐	Mental Retardation	☐	☐	Silicosis
☐	☐	Bronchitis	☐	☐	Head Injury	☐	☐	Multiple Sclerosis	☐	☐	Spinal Fusion
☐	☐	Cancer	☐	☐	Heart Condition	☐	☐	Muscle, Ligament or Tendon Injury	☐	☐	Stroke
☐	☐	Cardiac Disease	☐	☐	Heavy Metal Poisoning	☐	☐	Muscular Dystrophy	☐	☐	Sugar in Urine
☐	☐	Carpal Tunnel Syndrome	☐	☐	Hemophilia	☐	☐	Nervous Disorders	☐	☐	Surgical Removal of Intervertebral Disc
☐	☐	Cerebral Vascular Accident	☐	☐	High/Low Blood Pressure	☐	☐	Numbness of Extremities	☐	☐	Thrombophlebitis
☐	☐	Chronic Headaches	☐	☐	Hodgkin's Disease	☐	☐	Parkinson's Disease	☐	☐	Thoracic Outlet Syndrome
☐	☐	Chronic Osteomyelitis	☐	☐	Hyperinsulinism	☐	☐	Psychoneurotic Disability (following treatment in a recognized institution)			
			☐	☐	Hypertension						

If YES, please explain: _____

7. Do you have any other long-term health problems or adverse physical conditions? YES NO
   If YES, please explain: _____

Signature: _____ Date: _____

Name Printed: _____