

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

NAME: \_\_\_\_\_  
Last Name First Name Middle Initial

A. Job applied for:  
\_\_\_\_\_

B. How did you learn about this job?  
\_\_\_\_\_

C. Sex:  M  F

D. Present Marital Status:  
 Married  O

E. Birthdate: \_\_\_\_\_

F. Of the following, which group would you consider yourself a member?

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Spanish or Mexican American |
| <input type="checkbox"/> Black           | <input type="checkbox"/> White                       |
| <input type="checkbox"/> Oriental        | <input type="checkbox"/> Other _____                 |

G. Do you have a disability?

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> No           | <input type="checkbox"/> Yes-Paralysis          |
| <input type="checkbox"/> Yes-Blind    | <input type="checkbox"/> Yes-Cardiac            |
| <input type="checkbox"/> Yes-Deaf     | <input type="checkbox"/> Yes-Back Injury        |
| <input type="checkbox"/> Yes-Amputee  | <input type="checkbox"/> Yes-Other _____        |
| <input type="checkbox"/> Yes Epilepsy | <input type="checkbox"/> Yes-Veteran Disability |

### **TO ALL APPLICANTS**

The information requested on this card does not affect you as an applicant. This information will be used to find out how effective our recruitment efforts are in reaching all segments of the population, in the validation of our selection methods and for the purpose of Equal Employment Reporting.

Please give us your cooperation by completing this questionnaire.