



A Subsidiary of A&B, Inc.
 P.O. Box 530, Kalaheo, HI 96741, Ph. (808) 335-5481

An Equal Opportunity Employer
 M/F/V/H

Application For Employment

Personal (Please Print)

Full Name _____ Date _____
 Last First Middle

Present Mailing Address: _____
 P.O. Box/Street City State Zip

Telephone Number _____
 Where you can be contacted _____ Social Security Number _____

Have you ever applied with this company before? No Yes When? _____

How referred to us? _____

Are you authorized to work in the US.? No Yes

If you are offered and accept employment, you will be required to provide documentation which verifies both your identity and your authorization to work in the U.S. as required by law.

Education and Specialized Training

EDUCATION	SCHOOL NAME AND CITY	FIELD OF STUDY OR TRAINING	COMPLETED		DEGREE
			YES	NO	
High School			<input type="checkbox"/>	<input type="checkbox"/>	
College			<input type="checkbox"/>	<input type="checkbox"/>	
Other			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

Employment Skills

Type of employment desired _____

Salary desired _____ Date available for work _____

Typing _____ WPM Other _____

Other business machines _____

Employment History

FIRM NAME, CITY & IMMEDIATE SUPERVISOR	BASE SALARY	DESCRIBE POSITION AND DUTIES	DATES EMPLOYED	REASON FOR LEAVING
			MO./YR.	
			From: To:	
			From: To:	
			From: To:	

References (Excluding Relatives)

	NAME	ADDRESS	PHONE NO.
1			
2			
3			

Medical Information:

After an offer of employment is made, but before employment duties begin, applicants may be required to undergo a physical or medical examination at Company expense and by a Company-chosen physician, with the offer of employment conditioned on the result of such examination. Employees, at any time during the course of their employment, may be required to undergo a medical examination at Company expense and by a Company-chosen physician. I authorize the physician conducting the examination and any laboratory testing any specimen obtained by the physician to disclose the results of the examination and the laboratory test to the Company.

Applicant's Initials

Additional Information

READ AND SIGN BELOW

I certify that all statements made on this application are true and complete to the best of my knowledge.

I understand that my application will not be considered if it is incomplete.

I understand that if employed, misrepresentation or omission of facts is cause for dismissal.

This application is not a contract and cannot create a contract. I also understand that my employment is "at will" and can be terminated at any time by either party, with or without cause and with or without notice.

I authorize the Company to contact and make inquiries with the above listed references. I also authorize the references to release and provide any and all information concerning my previous or present employment, training and/or personal data from their records or other sources to the Company. I hereby release the references from any liability and/or damages whatsoever which may arise from or relate to their furnishing of such information to the Company.

SIGNATURE _____ DATE _____

This application will be considered active for a period of 30 days from the date it is completed and filed with the Company. Applicants must notify the Company during the last 10 days of this 30-day period if they wish to have their application remain active for another 30 days.