**NOTES:**  1. Please use black ink and capital letters

2. Please answer all questions

3. Please read all sections carefully and sign where applicable

**APPLICANT INFORMATION (Please Print)**

|  |  |
| --- | --- |
| Date of Application: |  |
| Full Legal Name: |  |
| Residence Address: |  |
| City / State (Prov) / Zip (Postal) |  |
| Cell Phone: |  |
| Residence Phone: |  |
| Social Security (Social Insurance) No.: |  |
| Position Applying for: |  |
| Availability: | Daytime Days: \_\_\_\_\_\_\_ \_\_\_AM to \_\_\_PM  Evening Days: \_\_\_\_\_\_\_ \_\_\_AM to \_\_\_PM  Overnight Days:\_\_\_\_\_\_ \_\_\_AM to \_\_\_PM |

**QUALIFIED APPLICANTS;**

|  |  |
| --- | --- |
| Applicants are required to have:  (Please mark on the next box)  \*Must pass a background check, drug test, and a lie-detector test\* | \_\_ Current BSIS CA Guard Card  \_\_ BSIS CA Exposed Firearms Permit  \_\_ Owns a Firearm - Depending on role  \_\_ Baton Permit  \_\_ Pepper Spray Permit  \_\_ CPR/First Aid/AED Certification  \_\_ Must be in Good Physical Condition  \_\_ Reliable Transportation  \_\_Combat training (MMA, BJJ) |

A-List employees are required to have flexibility, organization, attention to detail, and teamwork.

**EMPLOYMENT HISTORY**

|  |  |
| --- | --- |
| Employment Record for the past \_\_ years (starting with the current or most recent employer). For each position, provide the following:   * Start date and end date * Name of company * Position held * Brief job description * Contact name & phone number * Reason for leaving |  |
| Previous experience in security services (Give names, phone # of employers, and dates of employment for all positions. Indicate whether full-time or part-time). |  |

**Questions for Applicant:**

1. Have you ever applied to or worked for **A-List Protection** before?

\_\_\_ Yes \_\_\_ No

If yes, give date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you know anyone who currently works for **A-List Protection**?

\_\_\_\_ Yes \_\_\_ No

If yes, state the name and relationship of each person:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Why are you making this application to work for **A-List Protection**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Are you taking any medication? If so, list below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any medication allergies? If so, list below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use or do you have a history of using tobacco?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use or do you have a history of using illegal drugs?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any medical problems? If so, list below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*We are not responsible for any medical condition, under your employee liability you are in charge of informing the employer\*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR COMPANY USE ONLY:

|  |  |
| --- | --- |
|  |  |