



Moose Pharmacy is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, national origin, citizenship, age, or disability. We assure you that your opportunity for employment with Moose Pharmacy depends solely on your qualifications.

APPLICATION FOR EMPLOYMENT

(PLEASE PRINT)

DATE _____

PERSONAL DATA

LAST NAME _____ FIRST NAME _____ M.I. _____

SOCIAL SECURITY NUMBER _____ (FOR USE IN VERIFICATION OF EMPLOYMENT REFERENCES)

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME TELEPHONE _____ CELL/BUSINESS PHONE _____

E-MAIL ADDRESS _____

NOTIFY IN EMERGENCY

NAME _____

ADDRESS _____ PHONE _____

ARE YOU UNDER 18 YEARS OF AGE ___ YES ___ NO

LICENSE NUMBER OR ID NUMBER _____ STATE _____

HAVE YOU EVER BEEN EMPLOYED BY MOOSE PHARMACY BEFORE? _____

IF YES, PLEASE INDICATE FROM _____ TO _____

LIST NAMES OF FRIENDS OR RELATIVES, IF ANY, EMPLOYED BY MOOSE PHARMACY (GIVE RELATIONSHIP OF ALL) _____

POSITION APPLIED FOR _____

DATE YOU ARE AVAILABLE TO BEGIN WORK _____

DAYS YOU ARE AVAILABLE TO WORK _____

HOURS YOU ARE AVAILABLE TO WORK _____

*AS A CONDITION OF EMPLOYMENT WITH MOOSE PHARMACY, YOU MUST PROVIDE PROOF OF ELIGIBILITY TO WORK IN THE UNITED STATES, PURSUANT TO FEDERAL IMMIGRATION LAW.

PHYSICAL DATA

DO YOU HAVE THE ABILITY TO PERFORM EACH OF THE SPECIFIC FUNCTIONS OF THE JOB BEING SOUGHT? ____ YES ____ NO

IF NO, EXPLAIN FULLY AND STATE WHAT YOU FEEL MOOSE PHARMACY COULD REASONABLY DO TO ENABLE YOU TO PERFORM THE FUNCTIONS OF THE JOB.

MILITARY DATA

HAVE YOU BEEN IN THE MILITARY ____ YES ____ NO

IF YES, PLEASE INDICATE BRANCH, SERVICE DATES, AND FINAL RANK

SECURITY DATA

HAVE YOU EVER BEEN CONVICTED ____ YES ____ NO

IF YES, STATE OFFENSE AND DATE CONVICTED (OMIT MINOR TRAFFIC VIOLATIONS)

HAVE YOU EVERY BEEN BONDED ____ YES ____ NO

IF YES, GIVE NAME OF EMPLOYER AND DATE _____

EDUCATION DATA

SCHOOL OR TRAINING	NAME AND LOCATION	YEARS COMPLETED	COURSE OF STUDY	EQUIVALENCY DIPLOMA OR DEGREE EARNED
HIGH SCHOOL OR LAST GRADE COMPLETED				
COLLEGE				
BUSINESS, TECHNICAL TRADE, OR VOCATIONAL				
OTHER: POST GRADUATE, SPECIAL MILITARY TRAINING, OTHER SPECIAL COURSES				

PROFESSIONAL/TECHNICAL CERTIFICATION

PROFESSIONAL OR TECHNICAL SPECIALTY _____ LICENSE NUMBER _____

PRESENT LICENSE: ISSUE DATE _____ STATE _____

EXPIRATION DATE _____

NC LICENSE APPLIED FOR ____ YES ____ NO

ORIGINAL DATE OF LICENSURE _____

HAVE YOU EVER HAD PROFESSIONAL OR TECHNICAL LICENSE REVOKED? ___ YES ___NO
IF YES, PLEASE EXPLAIN _____

SPECIAL TRAINING OR SKILLS

LIST ANY OFFICE, MECHANICAL OR MEDICAL TRAINING OR CERTIFICATIONS, AND ANY OFFICE MACHINES OR EQUIPMENT YOU CAN OPERATE INCLUDING PERSONAL COMPUTER TYPES AND PROGRAMS: _____

EMPLOYMENT HISTORY

LIST ALL JOBS AND ACTIVITIES INCLUDING MILITARY SERVICE, SCHOOLS, PART TIME EMPLOYMENT WHILE IN SCHOOL, SELF EMPLOYMENT, AND PERIODS OF UNEMPLOYMENT FOR THE PAST 10 YEARS. PLEASE ALSO LIST SIGNIFICANT EXPERIENCE MORE THAN 10 YEARS AGO. BEGIN WITH THE MOST RECENT. DO NOT REFERENCE A RESUME. IF MORE SPACE IS NEEDED, PLEASE ASK FOR A CONTINUATION SHEET. PLEASE FILL IN ALL BLANKS.

PRESENT OR MOST RECENT:

EMPLOYER _____ PHONE _____

ADDRESS _____

NAME AND TITLE OF SUPERVISOR _____

POSITION(S) HELD _____ HOURS WORKED PER WEEK _____

DUTIES PERFORMED _____

DATE EMPLOYED _____ DATE SEPARATED _____ ENDING SALARY _____

MAY WE CONTACT THIS EMPLOYER? _____ YES _____ NO

EMPLOYER _____ PHONE _____

ADDRESS _____

NAME AND TITLE OF SUPERVISOR _____

POSITION(S) HELD _____ HOURS WORKED PER WEEK _____

DUTIES PERFORMED _____

DATE EMPLOYED _____ DATE SEPARATED _____ ENDING SALARY _____

MAY WE CONTACT THIS EMPLOYER? _____ YES _____ NO

EMPLOYER _____ PHONE _____

ADDRESS _____

NAME AND TITLE OF SUPERVISOR _____

POSITION(S) HELD _____ HOURS WORKED PER WEEK _____

DUTIES PERFORMED _____

DATE EMPLOYED _____ DATE SEPARATED _____ ENDING SALARY _____

MAY WE CONTACT THIS EMPLOYER? _____ YES _____ NO

EMPLOYER _____ PHONE _____

ADDRESS _____

NAME AND TITLE OF SUPERVISOR _____

POSITION(S) HELD _____ HOURS WORKED PER WEEK _____

DUTIES PERFORMED _____

DATE EMPLOYED _____ DATE SEPARATED _____ ENDING SALARY _____

MAY WE CONTACT THIS EMPLOYER? _____ YES _____ NO

REFERENCES

LIST THREE PEOPLE THAT ARE NOT RELATIVES OR FORMER EMPLOYERS YOU HAVE KNOWN FOR 5 OR MORE YEARS.

NAME	OCCUPATION	ADDRESS & TELEPHONE NUMBER	YEARS KNOWN

AFFIDAVIT

(READ CAREFULLY BEFORE SIGNING)

I UNDERSTAND THAT IF I AM EMPLOYED BY MOOSE PHARMACY THAT I WOULD BE ENTERING INTO A TERMINATION-AT-WILL RELATIONSHIP. I UNDERSTAND THAT MEANS THAT MY EMPLOYMENT IS NOT FOR A STATED PERIOD THAT I MAY BE TERMINATED WHENEVER IT IS IN MOOSE PHARMACY'S BEST INTEREST. I UNDERSTAND THAT I MAY BE TERMINATED AT ANY TIME WITH OR WITHOUT CAUSE. I UNDERSTAND THAT NO ONE CAN MAKE ANY ORAL STATEMENTS OR PROMISES REGARDING JOB TENURE OR JOB SECURITY, WHICH ARE CONTRARY TO THE ABOVE WRITTEN DECLARATIONS OF COMPANY POLICY REGARDING TERMINATION-AT-WILL.

I AUTHORIZE MOOSE PHARMACY TO INQUIRE OF MY FORMER EMPLOYERS, ALL REFERENCES AND COMPANIES NOTED HEREIN, APPROPRIATE CREDIT BUREAUS, LOCAL POLICE DEPARTMENTS, REGISTRARS OF MOTOR VEHICLES AND OTHER STATE AND FEDERAL BUREAUS AND DEPARTMENTS CONCERNING MY PAST EMPLOYMENT CHARACTER AND TO OBTAIN A COPY OF MY MOTOR VEHICLE RECORD. I RELEASE AND DISCHARGE ANY PARTY DELIVERING INFORMATION TO MOOSE PHARMACY OR ITS DULY AUTHORIZED REPRESENTATIVE PURSUANT TO THIS AUTHORIZATION FROM ANY LIABILITY, CLAIMS, CHARGES OR CAUSES OF ACTION WHICH I MIGHT HAVE AS THE RESULT OF THE DELIVERY OR DISCLOSURE OF SUCH INFORMATION.

I ACKNOWLEDGE THAT MOOSE PHARMACY HAS A "DRUG-FREE WORKPLACE POLICY." I AGREE, AS A CONDITION OF CONTINUING EMPLOYMENT, THAT I WILL NOT ENGAGE IN THE UNLAWFUL MANUFACTURE, USE, POSSESSION, SALE OR DISTRIBUTION OF CONTROLLED SUBSTANCES. I UNDERSTAND THAT VIOLATION OF THIS POLICY MAY RESULT IN IMMEDIATE TERMINATION OF EMPLOYMENT. I FURTHER AGREE TO SUBMIT TO DRUG TESTING OR SCREENING AS PERMITTED BY LAW AND REQUIRED BY MOOSE PHARMACY.

I CERTIFY THIS APPLICATION WAS COMPLETED BY ME, AND THAT ALL INFORMATION IN IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I WILL BE SUBJECT TO DISMISSAL IF ANYTHING IN THIS APPLICATION IS FOUND TO BE FALSE IN ANY PARTICULAR.

IF EMPLOYED, I AGREE THAT ALL CLAIMS RELATING TO MY EMPLOYMENT, OTHER THAN WORKER'S COMPENSATION CLAIMS OR CLAIMS ARISING UNDER A NON-COMPETE AGREEMENT, SHALL BE SETTLED EXCLUSIVELY BY EXPEDITED ARBITRATION, WITHOUT DISCOVERY. THERE SHALL BE ONE ARBITRATOR, CHOSEN BY THE AMERICAN ARBITRATION ASSOCIATION AND THE CLAIM OTHERWISE PROCESSED IN ACCORDANCE WITH AAA RULES. ANY AWARD TO ME SHALL BE LIMITED TO THE LESSER OF (i) ANY ACTUAL LOST WAGES, (ii) AN AMOUNT NOT TO EXCEED SIX MONTHS' WAGES, OR (iii) IN AN APPROPRIATE CASE, REINSTATEMENT. THE COST OF ARBITRATION SHALL BE SHARED EQUALLY BETWEEN ME AND THE COMPANY.

YOU MAY WISH TO CONSULT AN ATTORNEY PRIOR TO SIGNING THIS APPLICATION. IF SO, PLEASE TAKE THIS FORM WITH YOU. HOWEVER, YOU WILL NOT BE OFFERED EMPLOYMENT UNTIL IT IS SIGNED WITHOUT MODIFICATION AND RETURNED.

SIGNATURE OF APPLICANT _____ DATE _____