

# ALTERNATIVE WORK PROGRAM

All information must be complete. Failure to provide accurate information may be grounds for denial.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
LAST FIRST MIDDLE

Home Address \_\_\_\_\_  
STREET CITY ZIP CODE

Mailing Address (if different) \_\_\_\_\_  
STREET/P.O. BOX CITY ZIP CODE

Home Phone \_\_\_\_\_ City And State Of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_ CDL/ID# \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Color Eyes \_\_\_\_\_ Color Hair \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

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## EMPLOYER / SCHOOL INFORMATION

Employer/School \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY ZIP CODE

Phone# \_\_\_\_\_ Occupational/Work Skills \_\_\_\_\_

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## MEDICAL INFORMATION

(Circle One)

Are you under a doctor's care at this time? \_\_\_\_\_ YES NO

Are you taking medication at this time? \_\_\_\_\_ YES NO

Do you have any physical or mental condition which would prevent you from working outdoors in a job which could include lifting, landscaping, washing and waxing vehicles or other manual labor? \_\_\_\_\_ YES NO

Explain any YES answer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

Relationship to you? \_\_\_\_\_ Address \_\_\_\_\_

Your Signature \_\_\_\_\_

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FOR DEPARTMENTAL USE ONLY

CII# \_\_\_\_\_ FBI# \_\_\_\_\_

Work Site: \_\_\_\_\_ I.D. # \_\_\_\_\_

Reviewed by Officer: \_\_\_\_\_ Date: \_\_\_\_\_