



# Sierra Nevada Construction, Inc.

2055 E. Greg Street, Sparks, NV 89431

(775) 355-0420 · (775) 355-0535 Fax

## Employment Application

### Applicant Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_ *City State ZIP Code*

Phone: ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Position Applied for: \_\_\_\_\_

Union Affiliation:

Laborers: Local \_\_\_\_\_  Operators: Local \_\_\_\_\_ District # \_\_\_\_\_  Non-Union

Are you a citizen of the United States?  YES  NO If no, are you authorized to work in the U.S.?  YES  NO

Have you been employed with us in the past?  YES  NO

If yes, explain: \_\_\_\_\_

### Previous Employment

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

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Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**CDL Information (if Applicable)**

CDL CLASS:  A  
 B

ENDORSEMENTS:  HAZMAT  
 TANKER  
 DOUBLE/TRIPPLE

RESTRICTIONS: \_\_\_\_\_

YEARS DRIVING: \_\_\_\_\_

Give a rundown of the trucks you have operated before in the past:

- WATER TRUCK     DUMP TRUCK     BOOT TRUCK     TRANSPORT TRUCK  
 SWEEPER     SIDE DUMPS     BOTTOM DUMPS

**Disclaimer and Signature**

*I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.*

*Sierra Nevada Construction, Inc. provides equal opportunity employment for all persons and prohibits discrimination in employment because of race, color, sex, religion, national origin, age or disability.*

*Sierra Nevada Construction, Inc. is a drug free workplace. All prospective employees are subject to drug testing.*

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



## EEO Voluntary Self Identification Form

The Equal Employment Opportunity Commission (EEOC) requires all private employers with 100 or more employees as well as federal contractors and first-tier subcontractors with 50 or more employees AND contracts of at least \$50,000 complete an EEO-1 report each year. Covered employers must invite employees to self-identify gender and race for this report. Please note that the information provided on this form, or the report may be required to be reviewed by Federal or state agency officials in compliance with Section 709(c) of Title VII of the Civil Rights Act of 1964 and NRS 338.070.

Completion of this will not affect your opportunity for employment, or the terms or conditions of your employment. This form will be used for reporting purposes only, will be kept separate from all other personnel records and will remain confidential. Information is required to be reported Federally for the EEO-1 report, but you can waive consent to report this information to state agencies.

**NAME:** \_\_\_\_\_ **JOB TITLE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

What is your sex?  Male  Female  I choose to not disclose

What is your race/ethnicity? Please mark the **one box** that describes the race/ethnicity category which you primarily identify.

**Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

**White (Not Hispanic or Latino):** A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

**Black or African American (Not Hispanic or Latino):** A person having origins in any of the black racial groups of Africa.

**Native Hawaiian or Pacific Islander (Not Hispanic or Latino):** A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.

**Asian (Not Hispanic or Latino):** A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

**Native American or Alaska Native (Not Hispanic or Latino):** A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

**Two or more races (Not Hispanic or Latino):** All persons who identify with more than one of the above five races.

**I do not wish to disclose to state agencies per NRS 338.070.**





### **Affirmative Action: Invitation to Self-Identify as a Veteran (VEVRAA)**

As a government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA) of 1974, Sierra Nevada Construction is required to submit a report to the U.S. Department of Labor each year identifying the number of protected veterans who were newly hired, as well as the number of protected veterans who were employed. If you believe you belong to any of the categories of protected veterans listed below, please indicate so by checking the appropriate box.

I belong to the following classifications of protected veterans (choose all that apply):

**Disabled Veteran**

A "disabled veteran" is one of the following:

A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or a person who was discharged or released from active duty because of a service-connected disability.

**Recently Separated Veteran**

A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval or air service.

**Active Wartime or Campaign Badge Veteran**

An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

**Armed Forces Service Medal Veteran**

An "Armed Forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a U.S. military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

**I am a protected veteran, but I choose not to self-identify the classifications to which I belong.**

**I am NOT a protected veteran.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Section 3 Hiring Form – Employee/Employer Certification**

Construction projects that are awarded certain federal funding must give, to the greatest extent feasible, hiring and training prioritization to low-income individuals. **Responses are voluntary for applicants/ employees. Nothing on this form shall be used to determine employee pay or promotions.**

<b>Applicant/Employee Name:</b>	<b>Home Address:</b>

**SECTION 1: APPLICANT/EMPLOYEE CERTIFICATION (Applicant/Employee Completes this Section)**

**A. I am a Section 3 Worker if one of these applies (check all that apply):**

1.  **YES**, my individual income or the income for my household is listed below for county of home residence  
**(NOTE: Residents/recipients of the following benefits are likely to meet the low-income criteria: Medicaid – Public Assistance/TANF - SNAP/Food Stamps - Section 8-assisted housing - Public Housing)**
2.  **NO**, I do not meet the qualifications for Section 3 Employees OR I do not wish to answer.

If your individual income or household annual income for the previous calendar year fell below the income limit as established by HUD, you are a Section 3 Worker who is eligible for hiring priorities in a Section 3 Project. Please use the below information to determine if you meet the criteria for the first and fourth options of question #1:

Washoe County 2024						
Persons in Household	1	2	3	4	5	6
80 % (gross income)	\$56,700	\$64,800	\$72,900	\$80,950	\$87,450	\$93,950
Carson City County 2024						
Persons in Household	1	2	3	4	5	6
80 % (gross income)	\$51,700	\$59,100	\$66,500	\$73,850	\$79,800	\$85,700
Lyon County 2024						
Persons in Household	1	2	3	4	5	6
80 % (gross income)	\$51,700	\$59,100	\$66,500	\$73,850	\$79,800	\$85,700
Douglas County 2024						
Persons in Household	1	2	3	4	5	6
80 % (gross income)	\$56,400	\$64,450	\$72,500	\$80,550	\$87,000	\$93,450
Churchill County 2024						
Persons in Household	1	2	3	4	5	6
80 % (gross income)	\$53,350	\$60,950	\$68,550	\$76,150	\$82,250	\$88,350
Storey County 2024						
Persons in Household	1	2	3	4	5	6
80 % (gross income)	\$56,700	\$64,800	\$72,900	\$80,950	\$87,450	\$93,950

*Note: Household income amount includes all sources of income earned by those in the household who are 18+. Income limits are based on 2022 HUD numbers and are subject to change. See :<https://www.huduser.gov/portal/datasets/il.html>. This website also provides detailed explanations on how to calculate your annual income.*

**I (applicant/employee) certify that the above statements are true, complete, and correct to the best of my knowledge and belief.**

**Employee Signature** X \_\_\_\_\_

**Date** \_\_\_\_\_





## Voluntary Self-Identification of Disability

Form CC-305  
Page 1 of 1

OMB Control Number 1250-0005  
Expires 05/31/2023

Name: \_\_\_\_\_  
Employee ID: \_\_\_\_\_  
(if applicable)

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

### Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

### How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

### Please check one of the boxes below:

- Yes, I Have A Disability, Or Have A History/Record Of Having A Disability
- No, I Don't Have A Disability, Or A History/Record Of Having A Disability
- I Don't Wish To Answer

**PUBLIC BURDEN STATEMENT:** According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

### For Employer Use Only

Job Title: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

## Autoidentificación voluntaria de discapacidad

Formulario CC-305  
Página 1 de 1

Número de control de la OMB 1250-0005  
Vence el 31/May/2023

Nombre: \_\_\_\_\_  
Identificador de empleado: \_\_\_\_\_  
(si procede)

Fecha: \_\_\_\_\_

### ¿Por qué se le ha pedido que conteste este formulario?

Somos un contratista o subcontratista federal obligado por la ley a ofrecer igualdad de oportunidades de empleo a las personas calificadas con discapacidades. También estamos obligados a medir nuestro progreso hacia el objetivo de que al menos el 7% de nuestros empleados sean personas con discapacidades. Para ello, debemos preguntarle a nuestros aspirantes y empleados si tienen o alguna vez han tenido una discapacidad. Dado que una persona puede quedar discapacitada en cualquier momento, les pedimos a todos nuestros empleados que actualicen su información por lo menos cada cinco años.

Identificarse con una persona con discapacidad es voluntario, y esperamos que decida hacerlo. Su respuesta se mantendrá confidencial y no será vista por directivos encargados de la selección, ni por otras personas que tomen decisiones sobre el personal. Contestar el formulario no tendrá ningún efecto negativo para usted, sin importar si se ha autoidentificado en el pasado. Para obtener más información sobre este formulario o sobre las obligaciones de empleo igualitario de los contratistas federales en los términos de la Sección 503 de la Ley de Rehabilitación, visite el sitio de internet de la Oficina de Programas de Cumplimiento de Contratos Federales (OFCCP, por sus siglas en inglés) del Departamento de Trabajo de EE. UU. en [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

### ¿Cómo puede saber si tiene una discapacidad?

Se considera que tiene una discapacidad si tiene algún impedimento o trastorno médico, ya sea físico o mental, que limite sustancialmente una actividad importante de la vida, o si tiene un historial o registro de dicho impedimento o trastorno médico. *Las discapacidades incluyen, entre otras:*

- Autismo
- Enfermedades autoinmunes, como lupus, fibromialgia, artritis reumatoide o VIH/sida
- Ceguera o problemas de la vista
- Cáncer
- Enfermedad cardiovascular o cardíaca
- Enfermedad celíaca
- Parálisis cerebral
- Sordera o problemas del oído
- Depresión o ansiedad
- Diabetes
- Epilepsia
- Trastornos gastrointestinales, como enfermedad de Crohn o síndrome del intestino irritable
- Discapacidad intelectual
- Ausencia total o parcial de extremidades
- Trastornos del sistema nervioso, como migrañas, enfermedad de Parkinson o esclerosis múltiple
- Trastornos psiquiátricos, como trastorno bipolar, esquizofrenia, TEPT o depresión mayor

### Marque una de las siguientes casillas:

- Sí, tengo una discapacidad o un historial o registro de haber tenido una discapacidad
- No, no tengo una discapacidad ni un historial o registro de haber tenido una discapacidad
- No quiero responder

**DECLARACIÓN DE CARGA PÚBLICA:** De acuerdo con la Ley de Reducción de Trámites de 1995, nadie está obligado a responder un instrumento de recolección de información si dicho instrumento no muestra un número de control válido de la OMB. Contestar esta encuesta debe tomar alrededor de 5 minutos.

### Solamente para uso del empleador

Puesto: \_\_\_\_\_ Fecha de contratación: \_\_\_\_\_