Employment Application

MedPharm Group of Companies is an Affirmative Action/Equal Opportunity Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, religious creed, gender, sexual orientation, gender identity, gender expression, trans-gender, pregnancy, marital status, national origin, ancestry, citizenship status, age, disability, protected Veteran Status, genetics or any other characteristics protected by applicable federal or local law. EEO Is The Law.

***** NOTE: PLEASE ATTACH A RESUME**

Applicant Name: _____ Date: _____

Mailing Address: _____

Contact No.: _____ Email Address: _____

Position Applied For: _____ Date Available: _____

Type of Employment Desired: _____ Full-Time _____ Part-Time _____ Internship

Lowest Salary Accepted: _____ Referred by: _____

Do you have any objections to working overtime, if necessary?	☐ Yes	☐ No
Can you travel, if required by this job position?	☐ Yes	☐ No
Have you ever been previously employed by our organization?	☐ Yes	☐ No
Can you submit proof of legal employment authorization and identity?	☐ Yes	☐ No
If you are under 18, can you furnish a work permit, if it is required?	☐ Yes	☐ No
If selected for employment, are you willing to submit to drug screening?	☐ Yes	☐ No

EDUCATIONAL HISTORY	Institution Name and Location	Years Completed	Course of Study	Degrees Earned
High School				
College				
Technical Training				
Other				

EMPLOYMENT HISTORY

Please provide all employment information for your past four employers starting with the most recent:

Employer: _____ Position Held: _____
Address: _____ Telephone No.: _____
Immediate Supervisor and Title: _____
Dates Employed: From _____ to _____ Final Pay Rate: _____
Job Summary: _____
Reason for Leaving: _____

Employment Application

Employer: _____ Position Held: _____
Address: _____ Telephone No.: _____
Immediate Supervisor and Title: _____
Dates Employed: From _____ to _____ Final Pay Rate: _____
Job Summary: _____
Reason for Leaving: _____

Employer: _____ Position Held: _____
Address: _____ Telephone No.: _____
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Employer: _____ Position Held: _____
Address: _____ Telephone No.: _____
Immediate Supervisor and Title: _____
Dates Employed: From _____ to _____ Final Pay Rate: _____
Job Summary: _____
Reason for Leaving: _____

OTHER SKILLS AND QUALIFICATIONS

Summarize any job-related training, skills, certificates, and/or other qualifications:

_____
_____
_____

REFERENCES

List three professional references who are not relatives:

Names	Title	Years Known	Contact No.

CERTIFICATION

A false or dishonest answer to any question in this application may be grounds for ineligibility for employment, or for dismissal after appointment. I understand that all statements made in this application are subject to investigation, including a check for fingerprints, security clearances, and employment verification. I certify that all statements made in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith.

Signature: **Date:**

_____

VOLUNTARY SELF-IDENTIFICATION

(VETS-4212 and EEO-1 Reporting)

MedPharm Group of Companies is an Affirmative Action/Equal Opportunity Employer. As a government contractor subject to Executive Order 11246, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (VEVRAA), Section 503 of the Rehabilitation Act of 1973, and their implementing regulations in 41 CFR Chapter 60, MedPharm Group of Companies is required to submit reports to the U.S. Department of Labor and Equal Employment Opportunity Commission each year to identify the number of applicants and employees belonging to each specified protected veteran category, gender, disability status, and race/ethnicity category.

Submission of this information is voluntary, and refusal to provide it will not subject you to any adverse treatment. The information provided will be kept confidential, maintained separate from other personnel records and only accessed by the Human Resource Department. Please return completed forms to the HR department at hr@medpharmusa.net, mail or drop off to: ATTENTION HR: 138 Kayen Chando Street Dededo, Guam 96929.

Print Name: **Position Applied For:**

GENDER

☐ **Male** ☐ **Female** ☐ **I choose NOT to identify**

RACE/ETHNICITY (check ONE box)

☐	**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 and/or Other 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.
☐	**American Indian 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 maintain tribal affiliation or community attachment.
☐	**Two or more races *(not Hispanic or Latino)***	All persons who identify with more than one of the above races.
☐	**I choose NOT to identify**	

PROTECTED VETERANS (choose **ALL** that apply)

☐	***Active duty wartime or campaign badge Veteran*** - 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*** - any veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 FR 1209, 3 CFR, 1996 Comp., p. 159).
☐	***Disabled Veteran*** - (1) 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 (2) a person who was discharged or released from active duty because of a service-connected disability.
☐	***Recently Separated Veteran*** - a 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.
☐	**I am a protected veteran, but I choose not to self-identify the classifications to which I belong.**
☐	**I am NOT a protected veteran.**
☐	**I choose NOT to identify**

If you are a disabled veteran, it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations. This information will assist us in making reasonable accommodations for your disability.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

As part of the company's equal employment opportunity policy, MedPharm Group of Companies will also take affirmative action as called for by applicable laws and Executive Orders to ensure that minority group individuals, females, disabled veterans, recently separated veterans, other protected veterans, Armed Forces service medal veterans, and qualified disabled persons are introduced into our workforce and considered for promotional opportunities.

Signature: **Date:**

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: Date:

Employee ID: (if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- ☐ Yes, I have a disability, or have had one in the past
- ☐ No, I do not have a disability and have not had one in the past
- ☐ I do not want 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

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: Date of Hire: