

**OFFSHORE WINDFARM SUPPORT, LLC**  
**APPLICATION, BACKGROUND CHECK AND AUTHORIZATION**

Please read before completing ALL of the necessary Background forms.

All forms need to be legible and filled out with the most information you have on hand: otherwise it can hold up processing the application.

**Upon applying you need to send in copies of your**

\_\_\_\_\_ **DL and/ or State ID**

\_\_\_\_\_ **MMD and Licenses if applicable**

\_\_\_\_\_ **TWIC (if you have one)**

\_\_\_\_\_ **Cold Water Immersion and Survival Training.**

\_\_\_\_\_ **STCW Certificate (if you have one)**

\_\_\_\_\_ **PASSPORT (if you have one)**

**NOTE: You cannot work on a foreign flagged vessel without a valid Passport and STCW Certificate**

**Scan documents together and email to [Paul@Offshorewfs.com](mailto:Paul@Offshorewfs.com)**

Thank you.

*Paul Forsberg*

**PLEASE NOTE: Documents must be delivered via email, US mail or in person.  
Taking picture of forms with a phone is NOT acceptable and will not be  
processed.**

**PDF or Printed Format ONLY**

# OFFSHORE WINDFARM SUPPORT, LLC

## EMPLOYMENT APPLICATION

<b>APPLICANT INFORMATION</b>	
Last Name	First Name
Are you 18 Years or Older	___ Yes ___ No
Mailing Address Apartment/Unit #	
City	State Zip
Home Phone	Cell Phone
Emergency Contact Name	Emergency Contact Number
Email Address	
Driver's License Number	State of Issue Date of Expiration
MMD Type	Tonnage / Date of Exp:
STCW	Date of Exp:
TWIC	Date of Exp:
Passport	Date of Exp:
Other	

<b>FISHING / MARINE EXPERIENCE TRAINING</b>		
<b>Type of Fishing / Boat Name</b>	<b># Years</b>	<b>When to When</b>

**Use space below for notes:**

## CRIMINAL BACKGROUND

Have you ever been convicted of a felony? If Yes, please explain: Yes No

If Yes, please explain:

### SPECIAL CIRCUMSTANCES

Do you have any special circumstances that may prevent you from working all of your scheduled work, including extra hitches? Yes No

If you answered yes, please explain:

**EMPLOYMENT HISTORY** List all **FISHING OR MARINE RELATED** jobs starting with your current or most recent employer. Fill in all blanks completely. List all of your employment history, even if it is not related to the fishing industry. All gaps of employment will be questioned

**Current**

(Company / Boat Name)

Home Port

Type of Fishing

Responsibilities

Date of Hire / Date Resigned

Reason for leaving

**Past Employer**

(Company / Boat Name)

Home Port

Type of Fishing

Responsibilities

Date of Hire/ Date Resigned

Reason for leaving

**Past Employer**

(Company / Boat Name)

Home Port

Type of Fishing

Responsibilities

Date of Hire / Date Resigned

Reason for leaving

**EEO & VETERANS INFORMATION (VOLUNTARY)** In compliance with government regulations we are required to track the number of our applications by Gender, Race/Ethnicity, Veteran Status and position applied. This information will be kept separately from your application and will only be used in accordance with Federal and State regulations.

You are not required to provide this information. Your application for employment will be considered in the same manner whether or not you fill out this form.

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Race / Ethnic Group:		
	American Indian or Alaska Native	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.
	Asian	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.
	Black / African American	A person having origins in any of the black racial groups of Africa
	Hispanic / Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.
	Native Hawaiian / Pacific Islander	A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
	White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
	Two or more races	All persons who identify with more than one of the above five races.
	other (Please Specify)	

Veteran Status	
Veteran	
Non Veteran	
Disabled Veteran	
Vietnam Era Veteran	

## **AUTHORIZATION TO RELEASE INFORMATION**

This authorization shall expire upon this expiration date: \_\_\_\_\_

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to **Offshore Wind Farm Support, LLC**. I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

The information used or disclosed pursuant to the authorization may be subject to re disclosure by **Offshore Wind Farm Support, LLC** or other recipients and is no longer protected. This authorization also allows **Offshore Wind Farm Support, LLC** to verbally discuss the patient's medical condition and treatment options with the medical care provider or facility and allows **Offshore Wind Farm Support, LLC** to obtain medical opinions concerning the patient from the medical care provider or facility.

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signed:

\_\_\_\_\_

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

Printed Name \_\_\_\_\_

Social Security # \_\_\_\_\_