



GREATER PITTSTON REGIONAL
Compost Commission
Est. 2012

Greater Pittston Regional Compost Commission Application for Employment

35 Broad Street
Pittston, PA 18640
570.909.8556
www.pittstoncity.org



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Please note: This is a pre-employment questionnaire. Completion of this application is only the first step of a multi-step hiring process. Positions are filled in accordance with city personnel policies under the conditions set forth in specific job announcements and subject to appropriation of the governing body. To be considered, applications must be completely filled out and signed, any additional information required in the announcement included, and be received in the Office of the City Administrator by the deadline stated in the announcement. **The City of Pittston is an equal opportunity employer and does not discriminate on the basis of sex, age, race, sexual orientation, disability, religion, or marital status.**

POSITION APPLYING FOR: _____

CHECK ONE:

Part-Time/ Seasonal

DATE OF APPLICATION: _____

APPLICANT INFORMATION PLEASE PRINT ALL INFORMATION

FULL NAME: _____

SOCIAL SECURITY NUMBER: _____

CURRENT ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PREVIOUS ADDRESS IF LESS THAN THREE (3) YEARS AT PRESENT ADDRESS:

TELEPHONE: (_____) _____ **CELLPHONE:** (_____) _____

EMAIL: _____

EDUCATION

HIGH SCHOOL

NAME AND ADDRESS: _____

DID YOU GRADUATE: YES NO GED (DATE): _____

COLLEGE/UNIVERSITY

NAME AND ADDRESS: _____

FIELD OF STUDY: _____

DID YOU GRADUATE: YES (Degree Type: _____) NO (Anticipated Year of Graduation): _____

GRADUATE or PROFESSIONAL COLLEGE/UNIVERSITY

NAME AND ADDRESS: _____

FIELD OF STUDY: _____

DID YOU GRADUATE: YES (Degree Type: _____) NO (Anticipated Year of Graduation): _____

OTHER SCHOOL

NAME AND ADDRESS: _____

FIELD OF STUDY: _____

DID YOU GRADUATE: YES (Degree Type: _____) NO (Anticipated Year of Graduation): _____

OTHER EDUCATION/SKILLS/CERTIFICATIONS: _____

LANGUAGE PROFICIENCY

ENGLISH: SPEAK READ WRITE
SPANISH: SPEAK READ WRITE
OTHER: _____ SPEAK READ WRITE
OTHER: _____ SPEAK READ WRITE
SIGN LANGUAGE: YES

MILITARY SERVICE

(You will be asked to complete the Voluntary Self-Identification of Protected Veteran Status Form at the end of this application in addition to this section.)

NO YES

IF YES:
BRANCH: _____

DATES OF SERVICE: _____

CRIMINAL HISTORY

(A conviction will not necessarily disqualify you from employment.)

Have you been convicted of a local, state or federal offense? YES NO

IF "YES" PLEASE EXPLAIN: _____

DRIVER'S LICENSE

(Please refer to the particular job announcement to determine whether the position requires a driver's license and if so, what type.)

DRIVER'S LICENSE TYPE: REGULAR CDL NONE

DRIVER'S LICENSE NUMBER: _____ STATE OF ISSUE: _____

EMPLOYMENT HISTORY

Dates of Employment	Employer Name Most Recent Supervisor/Manager Address Telephone	Position Title & Final Salary	Reason for Leaving

May We Contact Your Current Employer? YES NO

REFERENCES

Please list 2 references. At least 1 professional reference is recommended.

NAME & ADDRESS	TELEPHONE & EMAIL	RELATIONSHIP TO APPLICANT

OTHER INFORMATION

List Here Any Other Factors or Information You Wish Considered: _____

CERTIFICATION

By signing this application, I certify that the statements made in this application are true and complete to the best of my knowledge and understanding, and understand that, if employed, falsified statements on this application shall be grounds for termination.

I authorize the investigation of all statements contained herein and the references and employers listed within this application to provide any and all information concerning my references, current and previous employment and any pertinent information they may have, personal or otherwise, and release the municipality from any and all liability for any damage that may result from the utilization of such information.

I understand that in accordance with the requirements of particular positions as indicated in the job announcement, additional information, such as a criminal background check, drug-test, and or credit check may be required as part of the application and or employment offer.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disability Act (ADA) or other relevant state, federal and local laws.

SIGNATURE OF APPLICANT: _____

DATE: _____

Voluntary Self-Identification of "Protected" Veteran Status

Why Are You Being Asked to Complete This Form?

This employer is a government entity subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA). VEVRAA requires Government entities to take affirmative action to employ and advance in employment protected veterans. To help us measure the effectiveness of our outreach and recruitment efforts of veterans, we are asking you to tell us if you are a veteran covered by VEVRAA.

Completing this form is completely voluntary, but we hope you fill it out. Any answer you give will be kept private and will not be used against you in any way.

For more information about this form or the equal employment obligations of Federal entities, 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 Are a Veteran Protected by VEVRAA?

Contrary to the name, VEVRAA does not just cover Vietnam Era veterans. It covers several categories of veterans from World War II, the Korean conflict, the Vietnam era, the Persian Gulf War, and other conflicts which are defined as occurring from August 2, 1990 to the present.

If you believe you belong to any of the categories of protected veterans, please indicate by checking the appropriate box below.

- I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED BELOW
- I AM NOT A PROTECTED VETERAN
- I DO NOT WISH TO ANSWER

NAME OF APPLICANT: _____

SIGNATURE OF APPLICANT: _____

DATE: _____

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

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

Name: _____

Date: _____

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:

Job Title: _____ Date of Hire: _____

Other Notes:

Name (Last, First, Middle Initial)	Social Security Number	Birthdate (Month and Year)

Agency Use Only

Privacy Act Statement

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U.S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. Regardless of your answer to question 1, go to question 2.

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Yes No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
<input type="checkbox"/> 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 maintains tribal affiliation or community attachment.
<input type="checkbox"/> 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.
<input type="checkbox"/> Black or African American	A person having origins in any of the black racial groups of Africa.
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<input type="checkbox"/> White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.