



"Security in Every Job"

Employment Application			
Please Select the Virginia Location for which you are applying: <input type="checkbox"/> Norfolk <input type="checkbox"/> Richmond <input type="checkbox"/> Manassas <input type="checkbox"/> Yorktown <input type="checkbox"/> Corporate			Maryland Location: <input type="checkbox"/> Jessup <input type="checkbox"/> Walkersville
Last Name	First Name	Middle Name	Today's Date:
Street Address	City	State	Zip
Home Phone	Cell Phone	Email Address:	
Have you ever worked for Hercules? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the month/year: _____ Location: _____			Expected rate of pay:
Are you able to perform the essential functions of the job for which you are applying, with or without reasonable accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No			Position Desired:
Are you available for full-time work? <input type="checkbox"/> Yes <input type="checkbox"/> No What days and hours can you work?			
Are there specific times that you cannot work? <input type="checkbox"/> Yes <input type="checkbox"/> No What days and hours are you unavailable to work?			
Do you have a reliable method of getting to work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If necessary for the job you are applying for, are you able to: Work overtime <input type="checkbox"/> Yes <input type="checkbox"/> No Provide a valid driver's license <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you legally eligible to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have relatives or friends working for Hercules? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide their full name and relationship:			
Special Training or Skills (e.g., Languages, Machine Operation, etc.):			
Are you 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, employment is subject to verification of minimum legal age requirements			

Education

Select (or enter) last year completed below:

High School: _____ Did you graduate? Yes No

Select (or enter) last year completed below:

College: _____ Did you graduate? Yes No

Degree(s): _____

Training courses completed: _____

What languages do you speak and write fluently? _____

Employment History

Please provide accurate full-time and/or part-time employment history. Provide your present or most recent employer first.

Company Name: _____ Telephone: _____

Address: _____ Employed (Month/Year):
From: _____ To: _____

Name of Supervisor: _____

Job Title/Duties: _____ Reason for leaving: _____

Company Name: _____ Telephone: _____

Address: _____ Employed (Month/Year):
From: _____ To: _____

Name of Supervisor: _____

Job Title/Duties: _____ Reason for leaving: _____

Company Name: _____ Telephone: _____

Address: _____ Employed (Month/Year):
From: _____ To: _____

Name of Supervisor: _____

Job Title/Duties: _____ Reason for leaving: _____

References	
Full Name:	Relationship:
Company:	Phone:
Address:	
Full Name:	Relationship:
Company:	Phone:
Address:	

Referral Source	
How did you hear about our job opening?	
<input type="checkbox"/> Company Website	<input type="checkbox"/> Employee Referral*
<input type="checkbox"/> Temp Agency	<input type="checkbox"/> Job Board
<input type="checkbox"/> Advertisement	<input type="checkbox"/> Walk-In
<input type="checkbox"/> Other (please explain): _____	
*Please provide the name of the Employee Referral:	

Certification & Signature	
<p>“UNDER MARYLAND LAW, AN EMPLOYER MAY NOT REQUIRE OR DEMAND, AS A CONDITION OF EMPLOYMENT, PROSPECTIVE EMPLOYMENT, OR CONTINUED EMPLOYMENT, THAT AN INDIVIDUAL SUBMIT TO OR TAKE A POLYGRAPH EXAMINATION OR SIMILAR TEST. AN EMPLOYER WHO VIOLATES THIS LAW IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT EXCEEDING \$100.”</p>	
<p>Hercules is an equal opportunity/affirmative action employer, supporting employment of qualified applicants without regard to race, color, religion, age, sex, sexual orientation, gender identity, national origin, citizen status, marital status, disability, or veteran status.</p>	
<p>I acknowledge that the Company follows an employment-at-will policy, such that I or the Company may terminate my employment at any time for any reason. I understand that this application is not a contract of employment. I understand that to be employed, I must be lawfully authorized to work in the United States and show the Company documentation that will prove this.</p>	
<p>I certify that all the statements made herein are true and accurate and understand that any falsification or omission may result in dismissal.</p>	
Your Signature: _____	Date: _____

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

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

Name: _____
Employee ID: _____
(if applicable)

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

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____

Declaración voluntaria de discapacidad

Formulario CC-305
Página 1 de 1

Número de Control OMB 1250-0005
Expira el 30/04/2026

Nombre: _____
Identificación del empleado: _____
(si procede)

Fecha: _____

¿Por qué se le pide que rellene este formulario?

Somos un contratista o subcontratista federal. La ley nos obliga a ofrecer igualdad de oportunidades de empleo a las personas con discapacidad cualificadas. Nuestro objetivo es que al menos el 7% de nuestros trabajadores sean personas con discapacidad. La ley dice que debemos medir nuestro progreso hacia este objetivo. Para ello, debemos preguntar a los solicitantes y a los empleados si tienen o han tenido alguna discapacidad. Las personas pueden convertirse en discapacitadas, por lo que debemos hacer esta pregunta al menos cada cinco años.

Rellenar este formulario es voluntario y esperamos que decida hacerlo. Su respuesta es confidencial. Nadie que tome decisiones de contratación la verá. Su decisión de rellenar el formulario y su respuesta no le perjudicarán en modo alguno. Si desea obtener más información sobre la ley o este formulario, visite el sitio web de la Oficina de Programas de Cumplimiento de Contratos Federales (OFCCP) del Departamento de Trabajo de EE.UU. en www.dol.gov/ofccp.

¿Cómo saber si tiene una discapacidad?

Una discapacidad es una condición que limita sustancialmente una o más de sus "actividades vitales principales". Si tiene o ha tenido alguna vez una afección de este tipo, usted es una persona con discapacidad. **Las discapacidades incluyen, pero no se limitan a:**

- Trastorno por consumo de alcohol u otras sustancias (sin consumir drogas ilegalmente en la actualidad)
- Trastorno autoinmune, por ejemplo, lupus, fibromialgia, artritis reumatoide, VIH/sida
- Ceguera o problemas de visión
- Cáncer (pasado o presente)
- Enfermedad cardiovascular o del corazón
- Enfermedad celíaca
- Parálisis cerebral
- Sordera o dificultades auditivas graves
- Diabetes
- Desfiguración, por ejemplo, desfiguración causada por quemaduras, heridas, accidentes o trastornos congénitos
- Epilepsia u otro trastorno convulsivo
- Trastornos gastrointestinales, por ejemplo, enfermedad de Crohn, síndrome del intestino irritable
- Discapacidad intelectual o del desarrollo
- Enfermedades mentales, por ejemplo, depresión, trastorno bipolar, trastorno de ansiedad, esquizofrenia o trastorno de estrés postraumático
- Ausencia total o parcial de miembros
- Problemas de movilidad que requieran el uso de una silla de ruedas, un escúter, un andador, una pierna ortopédica u otros dispositivos de apoyo
- Afección del sistema nervioso, por ejemplo, migrañas, enfermedad de Parkinson, esclerosis múltiple (EM)
- Neurodivergencia, por ejemplo, trastorno por déficit de atención con hiperactividad (TDAH), trastorno del espectro autista, dislexia, dispraxia u otras dificultades de aprendizaje
- Parálisis parcial o total (por cualquier causa)
- Afecciones pulmonares o respiratorias, por ejemplo, tuberculosis, asma, enfisema
- Baja estatura (enanismo)
- Lesión cerebral traumática

Marque una de las casillas siguientes:

- Sí, tengo una discapacidad o la he tenido en el pasado
- No, no tengo ninguna discapacidad ni la he tenido en el pasado
- No quiero contestar

DECLARACIÓN PÚBLICA DE CARGA: De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una recopilación de información a menos que dicha recopilación muestre un número de control OMB válido. Esta encuesta debería completarse en unos 5 minutos.

Para Uso Exclusivo del Empleado

Los empleadores pueden modificar esta sección del formulario según sea necesario a efectos de mantenimiento de registros.

Por ejemplo:

Título del puesto: _____ Fecha de contratación: _____



**Voluntary Self-Identification Form (EEO/Affirmative Action)
(For Applicants)**

Hercules is an equal opportunity/affirmative action employer. As a Government contractor, we are 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), which requires Government contractors to take affirmative action to employ and advance in employment protected veterans. Hercules will take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability or veteran status.

Completion of this form is voluntary and will not affect your opportunity for employment, or terms or conditions of employment. The information you provide will be kept **confidential** and it will not be used in a manner inconsistent with the act. **Refusal** to provide information will not subject you to any adverse treatment.

Name: _____ **Position Applied for:** _____

GENDER & RACE/ETHNICITY
(Check one of the descriptions below)

- Male** **Female**
- 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 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 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 don't wish to answer**

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

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.

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.

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.

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 United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

- I identify as one or more of the classifications of protected veteran listed below
- I am not a protected veteran
- I don't wish to answer

Date completed: _____