



BREDA COMPANY, INC.
A DBE Rebar Installation Specialist

6830 N. Eldridge Pkwy. #505 - Houston, Texas 77041
Phone (713) 937-9270 Fax (713) 937-6732

APPLICATION FOR EMPLOYMENT
(Pre-Employment Questionnaire)
AN EQUAL OPPORTUNITY EMPLOYER

PERSONAL INFORMATION

DATE: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

NAME: _____
LAST FIRST MIDDLE

CURRENT ADDRESS: _____
STREET/NUMBER APT# CITY STATE ZIP

PERMANENT ADDRESS: _____
STREET/NUMBER APT# CITY STATE ZIP

PHONE NUM: _____ - _____ - _____ ARE YOU AT LEAST 18 YEARS OF AGE? Yes: ____ No: ____

ARE YOU EITHER A U.S. CITIZEN OR AN ALIEN AUTHORIZED TO WORK IN THE UNITED STATES?
Yes: ____ No: ____

EMPLOYMENT DESIRED

POSITION DESIRED: _____ DATE YOU CAN START: _____

WAGE(S) DESIRED: \$ _____ / Hour

ARE YOU EMPLOYED NOW? (If So, with whom?): _____

MAY WE REQUIRE OF THIS EMPLOYER? Yes: ____ No: ____

HAVE YOU EVER APPLIED TO THIS COMPANY BEFORE? Yes: ____ No: ____

IF SO, WHICH BRANCH? _____ (DFW, Houston or Austin) WHEN? _____

**FIELD HOURLY WORK IS PART TIME EMPLOYMENT
ON A JOB BY JOB BASIS.**

ADMINISTRATIVE/SALARY WORK IS FULL TIME.

EDUCATION

NAME AND LOCATION OF SCHOOL YEARS ATTENDED DID YOU GRADUATE SUBJECTS STUDIED

HIGH SCHOOL

COLLEGE

TRADE/TECHNICAL
SCHOOL

FORMER EMPLOYERS (LIST BELOW LAST THREE EMPLOYERS STARTING WITH MOST RECENT)

DATE	NAME OF EMPLOYER	POSITION	SALARY	REASON FOR LEAVING
_____	_____	_____	_____	_____
TO	_____	_____	_____	_____

DATE	NAME OF EMPLOYER	POSITION	SALARY	REASON FOR LEAVING
_____	_____	_____	_____	_____
TO	_____	_____	_____	_____

DATE	NAME OF EMPLOYER	POSITION	SALARY	REASON FOR LEAVING
_____	_____	_____	_____	_____
TO	_____	_____	_____	_____

REFERENCES (LIST BELOW THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN FOR AT LEAST ONE YEAR)

	NAME	BUSINESS	ADDRESS	YEARS ACQUAINTED
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

PHYSICAL RECORD:

Do you have any physical limitations that would inhibit you from doing performing any work for which you are being considered? Yes: ____ No: ____

If yes, what can be done to accommodate your limitations? _____

Please Describe: _____

Please note: all field work requires employees to be bent over for long periods of time and repeatedly lift weights in excess of 80Lbs throughout the day.

In Case of Emergency, Notify: _____

NAME	ADDRESS	PHONE NUMBER
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By Signing Below You Agree to the Following:

"I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT, IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES LISTED ABOVE TO GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION THEY MAY HAVE, PERSONAL OR OTHERWISE, AND RELEASE ALL PARTIES FROM ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM FURNISHING THE SAME TO YOU.

I UNDERSTAND AND AGREE THAT, IF HIRED, MY EMPLOYMENT IS FOR NO DEFINITE PERIOD AND MAY, REGARDLESS OF THE DATE OF PAYMENT OF MY WAGES AND SALARY BE TEMRINATED AT ANY TIME WITHOUT PRIOR NOTICE."

DATE: _____ SIGNATURE: _____

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY: _____ DATE: _____

HIRED: YES ____ NO ____ POSITION _____ DEPT. _____ WAGE/SALARY _____

START DATE: _____ APPROVED BY: _____



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E-VERIFY NOTIFICATION / NOTIFICATION DE E-VERIFY

In accordance with Executive Order 12989, Breda Company, Inc. will E-Verify your Social Security number and right to work documents with the Social Security Administration and the Department of Homeland Security. If there are any discrepancies you will be notified.

De conformidad con la Orden Ejecutiva 12989, Breda Company, Inc. verificará electrónicamente su número de Seguridad Social y sus documentos de derecho a trabajar con la Administración del Seguro Social y el Departamento de Seguridad Nacional. Si hay discrepancias, se le notificará.

Signature / Firma

Date / Fecha

Name / Nombre



**BREDA COMPANY, INC.
DRUG-FREE WORKPLACE POLICY**

- All employees are prohibited from using or being under the influence of controlled substances, inhalants or alcoholic beverages during work hours, Except for the legal use of controlled substance prescribed by a licensed physician and which shall be used only in the manner, combination and quantity prescribed and which shall only be used by the person for whom it is prescribed.
- The unlawful manufacture, distribution, dispensation, possession, or use of controlled substances, inhalants or alcoholic beverages on Breda Company, Inc, premises or job sites or while conducting Breda Company, Inc. business off premises, is absolutely prohibited. Sanctions may include completion of an appropriate rehabilitation or assistance program, probation, expulsion, termination or referral to authorities for prosecution. If an employee has been convicted of a criminal drug statute, sanctions will be imposed within 30 days.
- Breda Company, Inc., recognizes that drug, inhalant and alcohol abuse may result In serious health, safety and security problems. The use of drugs, inhalants and alcohol may alter a person's mental alertness and impair physical ability to complete certain tasks. Consequently, if any employee whose off-duty use of drugs, inhalants or alcohol results in absenteeism, tardiness, or impairment of work performance, or is the cause of workplace accidents, the employee will be given a list of treatment and rehabilitation centers where they may seek assistance. All treatment or assistance will be at the employees own expense.
- The company may require an employee to be tested for drugs or alcohol if there is reasonable suspicion that the employee's job performance has been affected by the use of illicit drugs, inhalants or alcohol and there is reasonable belief that such impairment presents a risk to the physical safety of the employee or another person.
- The company will perform random drug screenings, at its discretion, to ensure compliance o four drug-free workplace policy.
- As a condition of employment, each employee must report any criminal drug statute conviction for a violation occurring in the workplace or on Breda Company, Inc. property to the company no later than five days after conviction. Imposed sanctions may take the form of personnel actions against the employee, up to, and including, termination or requiring the employee to participate in an approved drug abuse assistance or rehabilitation program at his or her own expense.

Signature

Date



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**NOTICE:
EMPLOYEES AND APPLICANTS FOR EMPLOYEMNT
EQUAL OPPORTUNITY POLICY OF BREDA COMPANY, INC.**

It is the operating policy of Breda Company, Inc. to assure that applicants are employed and that employees are treated fairly during employment, without regard to their race, religion, sex, color, national origin, age or disability. Such action shall include: employment upgrading, demotion, or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation and selection for training, including apprenticeship, pre-apprenticeship, and/or on the job training.

We also encourage the use of available training programs and will be happy to advise upon what programs are available, the entrance requirements for each, as well as assisting in applying for or entering such programs. Any supervisor will be glad to have you contact them.

Breda Company, Inc. is a Disadvantaged Business Enterprise (DBE), business that specializes in the installation of reinforcing steel, primarily on Highway Projects in Texas. We hope to diversify our work force. Therefore all qualified applicants, regardless of race, color, national origin, religion, gender, age (if over the age of 18), disability, or Vietnam veteran status are encouraged to apply. Blacks and Female applicants are strongly encouraged.

All present employees are requested to encourage any individual regardless of race, color, national origin, religion, gender, age (if over the age of 18), disability, sex or veteran status to make application for employment with this company or apply for training under available programs.

Any complaint of alleged discrimination by this company, its supervisors or employees, or any persons or organizations acting on behalf of the company should be immediately called to the attention of the Equal Employment Officer.

Daniel O'Brien is the EEO Officer for Breda Company and can be reached at the Houston office at: 713-937-9270.

Employees have the right to pursue complaints with the Equal Employment Opportunity Commission (EEOC) at 1-800-669-4000 and the Texas Commission for Human Rights (TCHR) at 1-512-437-3450. Retaliation against a person who files a charge of discrimination, participates in an investigation, or opposes an unlawful employment practice is prohibited. Any and all complaints will be processed in a timely manner between thirty and ninety (30-90) days.

Roberto Breda
President – Breda Company, Inc.
4/2012

AN EQUAL OPPORTUNITY EMPLOYER



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> QR Code - Section 1 Do Not Write In This Space </div>	

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page



LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

2021

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at www.irs.gov/W4App, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____ Multiply the number of other dependents by \$500 ▶ \$ _____ Add the amounts above and enter the total here 3 \$ _____		
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	▶ _____ ▶		▶ _____ ▶
	Employee's signature (This form is not valid unless you sign it.)		Date

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
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NOTICE DISTRIBUTION

I have received the Notice to Employees Concerning Workers' Compensation, the Notice of Injured Employee Rights, Responsibilities in the Texas Workers' Compensation System, and Breda Company, Inc.'s EEO Policy, and new health insurance marketplace coverage options and your health coverage.

Yo he recibido el Aviso sobre compensacion para trabajadores en Tejas, Aviso de derechos de empleados lesionados, Responsabilidades en el Sistema de Compensación para Trabajadores de Texas, y Política de EEO de Breda Company, Inc., y nuevas opciones de cobertura de mercado de seguros de salud y su cobertura de salud.

Signature / Firma

Date / Fecha

Print / Nombre



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact [Daniel O'Brien – 713-937-9270 or hr@bredacompanyinc.com](mailto:Daniel.O'Brien@bredacompanyinc.com)

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.



WORKWELL, TX

Employee Acknowledgment of Workers' Compensation Network

I have received information that informs me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this packet, I understand that:

- I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual Insurance Company at (844) 867-2338 to notify them of my choice.
- I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me to a specialist. If I need emergency care, I may go anywhere.
- Texas Mutual will pay the treating doctor and other network providers for the treatment for my compensable injury.
- I may have to pay the bill if I get health care from someone other than a network doctor without prior network approval.

Knowingly making a false workers' compensation claim may lead to a criminal investigation that could result in criminal penalties such as fines and imprisonment.

Signature

Date

Printed name

I live at:

Street address

City

State

Zip code

Name of employer: Breda Company, Inc.

Name of network: WorkWell, TX

To the employer:

Each employee must sign this form when you begin the program or within 3 days of being hired, and at the time an injury occurs. Please indicate at which point this acknowledgement was completed.

- Initiating the network program (companywide)
- Initial employee notification (new hire)
- Injury notification (Date of injury: / /)

Keep this completed form in the employee's personnel file. It could be requested by Texas Mutual.