INSTRUCTIONS FOR EMPLOYMENT APPLICATION

1. Complete all available spaces on the application (or attach resume with information requested).

2. Please return the completed application by mail to:

   Human Resources
   Parcels, Inc.
   P.O. Box 646
   New Castle, DE 19720

   or deliver to one of the following locations:

   Parcels, Inc.
   230 North Market Street
   Wilmington, DE 19801

   Parcels, Inc./Dover
   1111B South Governor's Avenue
   Dover, DE 19904

3. Any inquiries regarding the status of applications submitted to Parcels, Inc., may be directed to humanresources@parcelsinc.com or 302-254-7204.

APPLICATION FOR EMPLOYMENT

We consider applications for all positions without regard to race, color, religion, sex, pregnancy, gender identity, sexual orientation, national origin, age, disability, genetic information, marital status, veteran status, status as a volunteer emergency responder, or any other category protected by local, state, or federal law.

Please print clearly or type all responses on this form.

Personal:

Name:_____

Address: _____

City: _____ State:_____ Zip: _____

Phone # (____) _____ E-Mail Address: _____

General:

Position(s) applied for: _____

Date of application: _____ Referred by:_____

Education:

	School: ***Name & Address***	***Course of Study***	***Years Completed***	***Diploma/ Degree***
High School				
Undergraduate				
Graduate/ Professional				
Other (please specify)				

Job and Eligibility Status:

If you are under 18 years of age, can you provide required proof of your eligibility to work? ☐ Yes ☐ No

Have you ever filed an application with us?
If yes, please provide date(s): _____ ☐ Yes ☐ No

Have you ever been employed with us? ☐ Yes ☐ No
If yes, please provide date(s): _____

Do any of your friends or relatives work here? ☐ Yes ☐ No
If yes, state name and relationship: _____

Are you currently employed? ☐ Yes ☐ No

May we contact your present employer? ☐ Yes ☐ No

Are you eligible to be employed in this country? Proof of eligibility for employment will be required upon hire. ☐ Yes ☐ No

Date available to begin work: _____ Salary desired: _____

Are you available to work: ☐ Full time ☐ Part time

Work Experience:

(Start with your present or latest job. Include any job related military service assignments)

Dates (Mo/Yr.)	*Name Address and Phone Number*	*Salary*	*Position*	*Reason for Leaving*
From: To:				
From: To:				
From: To:				
From: To:				

Describe all job-related training received in the U.S. Military:

Personal and Professional References:

(Give the names of three persons, not related to you, whom you have known at least one year.)

Name	*Address and Phone Number*	*Business*	*Years Acquainted*

Availability:

How many hours per week do you wish to work?: _____

Please mark any time slots in which you are ***NOT AVAILABLE*** to work:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:00am							
8:00am							
9:00am							
10:00am							
11:00am							
12:00pm							
1:00pm							
2:00pm							
3:00pm							
4:00pm							
5:00pm							
6:00pm							
7:00pm							
8:00pm							
9:00pm							
10:00pm							
11:00pm							

Investigation:

Note: It is my understanding that as a condition of hire this organization performs criminal background checks and Division of Motor Vehicle checks.

Name:_____ Driver's License #: _____ State: _____

Social Security Number: _____

Signature: _____ Date:_____

Applicant's Statement:

I certify that all information submitted by me on this application is true and complete.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed one hundred and twenty (120) days and shall be kept on file for a period of three (3) years from the date of the application. Any applicant wishing to be considered for employment beyond this time should inquire as to whether or not applications are being accepted at this time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

Even in the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Employer.

Signature: _____ Date: _____

For office use ONLY. Do not write in the area below.

Hire Date: _____ Position/Department: _____ PT/FT: _____

Salary/Wage _____ ☐ per annum ☐ per hour

Date reporting for work: _____

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

COMPLETION OF THIS FORM IS ENTIRELY VOLUNTARY

Pre-Employment Applicant Data Form

Parcels, Inc. is an equal opportunity employer. All employment decisions, including hiring, are made without regard to an individual's race, color, religion, sex, pregnancy, gender identity, sexual orientation, national origin, age (over 40), disability, genetic information, marital status, status as a veteran or volunteer emergency responder, or any other basis protected by local, state, or federal law. The purpose of this form is to ensure that Parcels, Inc. is doing all that it can to attract and retain a highly skilled and diverse workforce. The data you provide on this form will be kept confidential, and will be used solely for statistical purposes. The form is processed and maintained separately from your employment application, and is not used in the interview or selection process. Completion of this form is entirely voluntary.

Voluntary Self-Identification

1. Application Date: _____

2. Position Applied For: _____

3. Applicant Name: _____

4. Social Security Number (Last 4 Digits Only): _____

5. Race/Ethnic Code:

□ Hispanic or Latino

□ White (Not Hispanic or Latino)

□ Black or African American

□ Two or More Races / Ethnicities

□ Native Hawaiian or Other Pacific Islander

□ Asian

□ American Indian or Alaskan Native

6. Sex/Gender Code:

□ Male

□ Female

□ Other / Prefer Not to Disclose

COMPLETION OF THIS FORM IS ENTIRELY VOLUNTARY

7. Voluntary Self-Identification of Disability:

The Americans with Disabilities Act provides employment protections to disabled individuals. You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. Many impairments may rise to the level of a disability, so a comprehensive list cannot be included. Please note that any information provided in response to this inquiry will be kept confidential, and will not be used against you in any manner.

□ Yes, I have a disability (or previously had a disability

□ No, I don't have a disability

□ I don't wish to answer

Employee Name (Print)

Date

Signature