



# Florida Carpenters Training Trust Fund

United Brotherhood of Carpenters and Joiners of America

**Central Office:** 2840 NW 27th Avenue, Fort Lauderdale, Florida 33311

Tel: (954) 739-9200 - Fax: (954) 739-6461

Welcome,

We take this opportunity to welcome you to the Florida Carpenters Training Trust Fund Apprenticeship Program. Our mission is to provide quality training and education that will keep you in the forefront of the construction industries. Our Carpenters and Pile Drivers are the best in the business because of the training we provide.

Our Training Program is State approved in Florida and many companies rely on us to provide them a modern, safety trained workforce capable of performing at the highest standards.

Please read this application packet carefully and completely. Sign and date all pages that request you to do so. Do not forget to provide us with a Driver's license and a Social Security Card.

Please note that we do not provide any employment at the Training Centers. If you have any questions regarding work assignments, you must contact your Local Union Representatives.

## **AFFILIATED LOCAL UNIONS: 702, 1809 AND 1905**

<b><u>Local</u></b>	<b><u>Location</u></b>	<b><u>Phone Number</u></b>	<b><u>Craft</u></b>
702	North Florida – Jacksonville	(904) 387-4471	General Carpentry
1905	Central Florida – Orlando	(407) 384-1214	General Carpentry
	Tampa	(813) 988-3997	General Carpentry
1809	South Florida – Fort Lauderdale	(954) 739-9200	General Carpentry Pile Drivers

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## Apprenticeship Application Check List

**Location** (please check one)

North Florida ☐

Central Florida: Orlando ☐ Tampa ☐

South Florida ☐

1. Completed Application Form
2. Copy of ALL Academic Transcripts
3. Copy of Social Security Card
4. Copy of Valid Government Issued Identification
5. Proof of Citizenship or INS Card
6. Copies of all certificates earned (example: OSHA, Welding, etc.)
7. Information page for correspondence

**\*\*\*\*\*Every item on this Checklist must be completed before submitting this Application back to the Training Office. No Application will be processed until each item is attached.**



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## INFORMATION PAGE

TODAY'S DATE: \_\_\_\_\_ APPLICATION or UBC NUMBER: \_\_\_\_\_  
Office Use Only

CRAFT: CARPENTER \_\_\_\_\_ PILE DRIVER \_\_\_\_\_ FLOOR COVERER \_\_\_\_\_

NAME: \_\_\_\_\_

CELL PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

By completing the above information, I am agreeing to receive communications via text message and email and I also agree to keep my contact information current to include mailing address, cell phone number and email address.  
Any changes should be reported as soon as possible.



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Central Office: 2840 NW 27th Avenue, Ft. Lauderdale, Florida, 33311

Tel: 954.739.9200 ~ Fax: 954.739.6461

**\*\* I hereby make Application for**    Carpenter ☐                      Pile Driver ☐                      Floor Coverer ☐

Date: \_\_\_\_\_ Social Security: \_\_\_\_\_ Email: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Emergency Contact/ Phone: \_\_\_\_\_

Country or State of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender: Male ☐ Female ☐ Unstated ☐

Ethnic Group/Race :    White ☐    African American ☐    Hispanic ☐    Pacific Islander ☐    Asian ☐    American Indian ☐  
Other ☐ Please Specify \_\_\_\_\_

## **EQUAL OPPORTUNITY PLEDGE:**

The recruitment, selection, employment, and training of apprentices during their apprenticeship, shall be without discrimination because of race, color, religion, national origin, sex, or any other classification protected under all applicable State and Federal laws.

Have you applied to an Apprenticeship Program before?    Yes: ☐    No : ☐    Year? \_\_\_\_\_

Do you have the minimum tools on the toollist? (attached)    Yes: ☐    No : ☐

Have you previously worked in the construction industry?    Yes: ☐    No : ☐    Year? \_\_\_\_\_

Do you have a valid government issued identification?    Yes: ☐    No : ☐

Do you have reliable transportation to school and/or work?    Yes: ☐    No : ☐

What was the highest level/grade of education completed? Level/Grade \_\_\_\_\_ Year: \_\_\_\_\_

\_Diploma    Yes: ☐    No ☐    G .E.D.    Yes ☐    No ☐

How did you learn about this Program? \_\_\_\_\_

What is your reason for enrolling in this Program? \_\_\_\_\_

Are you physically able to perform construction work?    Yes: ☐    No ☐

Are you a Veteran?    Yes: ☐    No ☐    Please attach a copy of your DD214

**I have read and understand this entire Application for Apprenticeship and my signature indicates all my responses on the Application are true and correct.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Tool List and Clothing Attire Information

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After completing the application, please be aware of the following basic tools and the type of clothing **required** for school and work.

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**CLOTHING:**     **Work boots**     **Long Pants**     **Shirt with sleeves**     **Hard Hat**

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## Carpenter Apprentice

Minimal tools for the first day on the job unless told otherwise:

20 oz. Claw Hammer	25-foot x 1 inch wide Measuring Tape
Nail Apron/Pouch	Utility Knife
Pencils	Safety Glasses or Goggles
Chalk Line	Hearing Protection
Speed Square	

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## Pile Driver Apprentice

Minimal tools for the first day on the job unless told otherwise:

Straight Claw Hammer	
Large Screwdriver	Small Hand-Pinch Bar
3-foot Crow Bar	12-inch Crescent Wrench
Torch Striker	Safety Glasses or Goggles
25-foot x 1 inch wide Measuring Tape	Hearing Protection
	Rubber Boots

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The above tools are required. You are responsible for purchasing additional hand tools as needed for use on the job and/or school. A good idea is to purchase a few tools every week, (as soon as you are employed) in order to build your toolbox.

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## Former Employer's Information

◆ Employer's Name:

\_\_\_\_\_

◆ Employer's Address:

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ May we contact your employer for reference? \_\_\_\_\_

Supervisor's name: \_\_\_\_\_

Work Performed: \_\_\_\_\_

\_\_\_\_\_

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

Starting Wage Rate: \_\_\_\_\_ Ending Wage Rate: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

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◆ Employer's Name:

\_\_\_\_\_

◆ Employer's Address:

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ May we contact your employer for reference? \_\_\_\_\_

Supervisor's name: \_\_\_\_\_

Work Performed: \_\_\_\_\_

\_\_\_\_\_

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

Starting Wage Rate: \_\_\_\_\_ Ending Wage Rate: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

### *Office use only*

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

## Former Employer's Information

◆ Employer's Name:

\_\_\_\_\_

◆ Employer's Address:

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ May we contact your employer for reference? \_\_\_\_\_

Supervisor's name: \_\_\_\_\_

Work Performed: \_\_\_\_\_

\_\_\_\_\_

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

Starting Wage Rate: \_\_\_\_\_ Ending Wage Rate: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

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◆ Employer's Name:

\_\_\_\_\_

◆ Employer's Address:

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ May we contact your employer for reference? \_\_\_\_\_

Supervisor's name: \_\_\_\_\_

Work Performed: \_\_\_\_\_

\_\_\_\_\_

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

Starting Wage Rate: \_\_\_\_\_ Ending Wage Rate: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

### *Office use only*

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

## Voluntary Self-Identification of Disability

Form CC-305  
Page 1 of 1

OMB Control Number 1250-0005  
Expires 05/31/2023

Name: \_\_\_\_\_  
Employee ID: \_\_\_\_\_  
(if applicable)

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

### Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

### How do you know if you have a disability?

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. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

### Please check one of the boxes below:

- ☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability  
No, I Don't Have A Disability, Or A History/Record Of Having A Disability
- ☐ I Don't Wish 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: \_\_\_\_\_