REGISTRANT APPLICATION FORM
SCDOT Advanced Work Zone Traffic Control – Design/Supervisor Course

INSTRUCTIONS: Complete both PART 1 AND PART 2 of this application for each registrant.

PART 1: APPLICANT INFORMATION

Legal/Proper Name: _________________________________________________________________
(As it appears on your Drivers License/ID Card)

Last 4 digits of SS#: ______________________________ Phone: ____________________________

Email: __________________________________________________________________________

Applicant’s current position with current employer (include brief description of duties):
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

If less than 2 years, list your previous position with your current company (include brief description of duties): *If your previous experience is not with your current employer, please complete the “Previous Employer” section on the next page.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Dates of employment with current employer: ____________________________________________

Driver’s License or Identification Number (include state of issue) __________________________

1 of 3
PREVIOUS EMPLOYER: (complete this section if less than 2 years work history with current employer)

Company Name: __________________________________________________________________________

Company Address: _________________________________________________________________________

City / State/ Zip: __________________________________________________________________________

Dates of Employment: ______________________________ Job Title:______________________________

Brief description of duties: __________________________________________________________________

________________________________________________________________________________________

Company Contact: _______________________________ Phone: ________________________________

Company Contact Email: ____________________________________________________________________

I certify that the information contained on this form is correct and complete. I authorize the Carolinas AGC Foundation to contact my current and former employer to confirm my work experience. I also understand that this is a 3 day course and that I must attend the entire course, take and pass a test with a score of 80% or better and that in order to take this course, I must have at least 2 years of relevant work experience verified by my employer(s). I further understand that I must have the ability to perform basic math, including calculations using multiplication, division, and fractions AND English reading fluency and comprehension is a must as this course is not offered in Spanish.

_________________________________________  Date:__________________________________

Signature of Applicant: _______________________

Printed Name: _______________________________  Title:_______________________
PART 2: CURRENT COMPANY/EMPLOYER INFORMATION

Employer information to be completed and signed by an authorized company representative.

Company Name: __________________________________________________________________________

Company Address: _________________________________________________________________________

City / State/ Zip: ___________________________________________________________________________

Company Representative: ___________________________ Title: ________________________________

Email: ____________________________________________________ Phone: _________________________

I certify that I am an authorized to sign this form on behalf of my company and that the information contained in Parts 1 and 2 of this form is correct.

________________________________________________________________________________________

Signature of Company Representative                                   Date:

________________________________________________________________________________________

Printed Name:         Title:

FINAL APPLICANT INSTRUCTIONS:

Upon completion of this application please remit, via fax or email to the following no later than 5 business days prior to the class date:

Bill Stricker, Carolinas AGC Foundation
Fax: 704-332-5032
Email: BStricker@CarolinasAGC.org