

# Diversity Questionnaire

Name \_\_\_\_\_

Position \_\_\_\_\_

The company is required by law to report the composition of its employment force to the government. Your voluntary cooperation will be appreciated. The information on this form will be filed separately from the main application form and will not be accessible to those processing your application. Safeguards are used to prevent the discriminatory abuse of this information. It will be available only to the person responsible for government reporting purposes.

**RACE/ETHNICITY:** Which race/ethnicity do you consider yourself to be? If you are of more than one race, please also check "Multi-Racial" below and indicate your preference for Affirmative Action purposes.

- |   |   |
|---|---|
| <input type="checkbox"/> White  | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Native American or Alaskan Native                      | <input type="checkbox"/> Japanese               |
| <input type="checkbox"/> Native Hawaiian  | <input type="checkbox"/> Korean                 |
| <input type="checkbox"/> Chinese  | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Filipino   | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Asian Indian   | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Multi-Racial, preference for reporting purposes: _____ |   |

**SPANISH/HISPANIC/LATINO ORIGIN:** Are you of Spanish/Hispanic/Latino Origin?

- No, not Spanish/Hispanic/Latino  
 Yes, Mexican/Mexican American  
 Yes, other Spanish/Hispanic/

**VETERAN STATUS:** Are you a veteran of the U.S. armed forces?  Yes  No

**If YES, please check one of the following:**

- |   |  |
|---|--|
| <input type="checkbox"/> Disabled Veteran/Vietnam-era | <input type="checkbox"/> Vietnam-era Veteran |
| <input type="checkbox"/> Spouse of Disabled Veteran   |  |
| <input type="checkbox"/> Other Veteran                | <input type="checkbox"/> Disabled            |

**GENDER:**  Male  Female

**DATE OF BIRTH** \_\_\_\_\_

**DISABILITY STATUS:** Do you have a physical, sensory, or mental impairment which limits your ability to perform job functions without special accommodations?

- Yes  No

**REFERRAL INFORMATION:** How did you find out about this opening?

- |   |   |
|---|---|
| <input type="checkbox"/> Walk-In                      | <input type="checkbox"/> Newspaper - Print name _____         |
| <input type="checkbox"/> Announcement                 | <input type="checkbox"/> Public Agency - Print name _____     |
| <input type="checkbox"/> Friend                       | <input type="checkbox"/> Internet - Please specify site _____ |
| <input type="checkbox"/> Other - Please specify _____ |   |

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**THIS SUPPLEMENTAL INFORMATION IS FOR RECORD KEEPING ONLY**

*Note: This document is for informational purposes only and may not be appropriate for your situation. Please consult an attorney for all legal matters.*