

Heavy Equipment Technology Program

A Partnership between
Wilco Area Career Center & ASIP Local 150 Operating Engineers

APPLICATION

Items to be submitted:

- ☐ Application
- ☐ High School Transcript recommended 2.5 GPA
- ☐ Proof of Attendance documenting 95% attendance rate
- ☐ 2 Faculty Recommendations (1 CTE instructor, 1 other teacher/counselor/administrator)
- ☐ Recommended completion of 1 Industrial CTE course

Only seniors for the upcoming school year are eligible to apply.
Students must pass a drug test which will be administered by ASIP Local 150
Operating Engineers.

Due Date:

February 6, 2026

Student Application Heavy Equipment Technology

A Partnership between
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Name _____ Date _____
(Last) (First) (MI)

Home Address _____
(Street) (City) (Zip code)

Date of Birth _____ Home Phone _____

Parent cell phone: _____ Student cell phone: _____

Home School _____ Student E-mail: _____

Parents or Guardian _____ Parent E-mail: _____

Current Year Courses (Including both semesters)

Career & Technical Courses	1 st Semester Grade	Current Grade	Teacher
Other Courses			

Please attach a copy of your high school transcript.

What are your career goals? _____

What are your post-secondary educational plans? _____

Have you applied to, been accepted by, or plan to apply to a post-secondary educational institution? _____ Yes _____ No

If yes, name of Institutions (s) and major
Institution

Major Area of study

Why are you interested in participating in the heavy equipment technology program?
(Additional space may be used to complete your answer.)

Do your parents know of your interest in the program? _____ Yes _____ No

In making this application I accept responsibility for maintaining eligibility, following the rules, which have been established for participation. I certify that all the statements made above by me, in this application are true, complete and correct to the best of my knowledge, and I am aware that any false statements will be sufficient cause for dismissal from the program. Unless notified in writing by the student's parent/guardian stating that they do not wish their child's picture to be used for public use, pictures taken of students may be placed in publications, display or presentations. This includes but not limited to videos, computers, website or articles placed in newspapers. I am also aware that the student must pass a drug test that will be administered by ASIP Local 150 Operating Engineers.

Student Signature

Date

Student (printed name)

I consent to _____ (student name) participating in the heavy equipment technology program at ASIP Local 150 Operating Engineers.

Parent or Guardian

Date

Heavy Equipment Technology Program

First Semester Attendance Record

Must be completed by school personnel
(To accompany Application Form)

Student _____

School _____

Number of days in 1st Semester _____

Number of full days attended _____

Number of partial days attended _____

Please explain partial days if in excess of 5: _____

Signature of school personnel
completing form

Title

Date

WILCO-ASIP LOCAL 150
HEAVY EQUIPMENT TECHNOLOGY PROGRAM
Faculty Recommendation

Student Name _____

This student has applied for participation in the Wilco-ASIP Local 150 Operating Engineers Heavy Equipment Technology Program. Would you help in the selection process by providing the following information about this student?

Teacher Name _____

In what capacity do you know the student? _____

Please rate this student on the following areas:

5=Superior 4=Above Average 3=Average 2=Below Average 1=Unsatisfactory

Category	Excellent	Above Average	Average	Below Average	Unsatisfactory
Reliability					
Leadership					
Industriousness					
Knowledge of Subject Matter					
Getting Along with Others					

_____ Attitude: Comments:

_____ Motivation: Comments:

_____ Desire to Succeed: Comments:

Why should this student be considered for the Heavy Equipment Technology Program?

Faculty Signature

Date

WILCO AREA CAREER CENTER

500 Wilco Blvd.
Romeoville, IL 60446

PHYSICAL EXAM FORM

To be completed by student:

Name _____ Home School _____

Address _____
Street City State Zip

Phone # _____

E-mail address _____

Birthdate _____ Age _____

Person to notify in case of emergency:

Name _____

Phone# _____

Relationship _____

Family Physician _____

Phone _____

Address _____

To be completed by physician:

Immunizations:

Tuberculosis skin test: #1. Date given: _____ Date read/reaction: _____
(2-step Mantoux)

#2. Date given: _____ Date read/reaction: _____

TB Tine test is not acceptable.

Documentation of a 2 Step TB Mantoux test is required prior to the start of clinicals. The second Mantoux test must be administered within 7-21 days of the first test, if the reaction to the initial test is negative. A single step Mantoux is adequate if a 2 step Mantoux was done within the past year. **TB Tine is not acceptable.** If a student has a recorded positive Mantoux, a chest x-ray is required.

*Reaction at test site should be read within 48-72 hours.

PHYSICIAN: In the section below, denote whether area is within normal limits (WNL) or abnormal. Record details in the remarks section.

WNL

ABNORMAL

_____	_____ General Appearance
_____	_____ Eyes (Include lids, pupils, fundi, EOM)
_____	_____ Nose
_____	_____ Mouth
_____	_____ Throat (Include pharynx, tonsils)
_____	_____ Teeth and Gums
_____	_____ Neck (Include carotids and thyroid)
_____	_____ Lymph Nodes (cervical axillary, inguinal, epitrochlear)
_____	_____ Chest and lungs
_____	_____ Heart (Size, rhythm, murmur, quality of tones, thrill)
_____	_____ Abdomen (appearance, liver, spleen, scars, mass, tenderness)
_____	_____ Hernia (umbilical, inguinal, femoral, incisional)
_____	_____ Extremities (Feet, edema, pulses, ROM, deformity)
_____	_____ Skin
_____	_____ Rectal
_____	_____ Pelvic
_____	_____ Back (attention to list, pelvic, tilt, scoliosis, ROM)
_____	_____ Neurological (Include reflexes)

Explain any checks in the abnormal section. (Note asthma or diabetes)

Student is able to participate in all aspects of the course (clinical included) without restrictions.

Physician signature: _____ Date: _____

Physician name printed: _____

Street Address City State Zip Code

Phone # _____

OFFICE USE:

DATE RECEIVED _____