



employer solutions staffing group^{inc}
Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405
Edina, MN 55439
Tel: 952.835.1288 • Fax: 952.835.1255
www.esgstaffingsolutions.com

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Linan First Name Adrin Middle Initial A
Street Address 10350 Dover St. Apt/Ste B15
City/State/Zip Westminster / Colorado / 80021
Phone Number 719-213-6493 Email Address linan.adrin@gmail.com
Staffing Agency/Recruitment Partner CMG

All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

Are you legally authorized to work in the United States of America? ☒ YES ☐ NO

Applicant Certification and Authorization

I authorize Employer Solutions Staffing Group (ESSG) to use the information and statements contained in this application to determine my qualifications for employment. I authorize ESSG to make inquiries of my former employers, except as indicated in this application, regarding my previous duties, responsibilities, performance, compensation and eligibility for rehire.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.

I release ESSG and other persons or entities from any claims that might be based on ESSG's decision to conduct a background check.

I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

If hired, I agree to abide by the policies and procedures of ESSG.

Adrin Linan
Name (Print or type)

[Signature]
Applicant's Signature

5/18/15
Date

A copy or facsimile ("fax") will be considered the same as an original signature. Email will ONLY be used for employment correspondence

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (If applicable) _____	ESC Application _____
For ESSG Client Use				
DOH _____	ROP _____	Work Site Loc. _____	WC Code _____	

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u>1</u>
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.	B	<u>1</u>
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	_____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	_____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	_____
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F	_____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$65,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child	G	_____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶	H	<u>2</u>

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074
▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		2015		
1	Your first name and middle initial <u>Adrian A</u>	Last name <u>Linan</u>	2	Your social security number <u>523-79-5484</u>
Home address (number and street or rural route) <u>10350 Dover St. Apt. B15</u>			3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code <u>Westminster CO 80021</u>			4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	
5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)			5 <u>2</u>
6	Additional amount, if any, you want withheld from each paycheck			6 \$ <u>0</u>
7	I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ <u>7</u>			
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (This form is not valid unless you sign it.) ▶ <u>Adrian Linan</u>				
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)			9 Office code (optional)	10 Employer identification number (EIN)



Revision Date: 09/01/14
Expiration Date: 10/01/17

Affirmation of Legal Work Status

Pursuant to § 8-2-122, Colorado Revised Statutes

Employee Name: Linan Adrin A 12/16/1990
Last First Middle Date of Birth

Social Security Number: 523 79 5485 Date of Hire: 5/18/15 (MM/DD/YYYY)

In accordance with § 8-2-122, C.R.S., within 20 calendar days after hiring the new employee listed above,

I affirm all four of the following by signing this form:

1. I have examined the legal work status of the above named employee.
2. I have retained file copies of the documents required by 8 U.S.C. sec. 1324a.
3. I have not altered or falsified the employee's identification documents.
4. I have not knowingly hired an unauthorized alien.

Casey Mayo Account Rep.
Print Name of Employer (or Designated Representative) Official Title

Casey Mayo 5/19/15 (MM/DD/YYYY)
Signature of Employer (or Designated Representative) Date Signed by Employer

Corporate Management Group 720.471.0614
Business or Organization Name Employer Phone Number

The provision of false or fraudulent information on this form may subject the employer to a significant fine and/or additional penalties.

This form and the documents required by 8 U.S.C. sec. 1324 (copies or electronic copies) will be retained for the duration of the above named individual's employment.

§ 8-2-122(2), C.R.S.: On and after January 1, 2007, within twenty days after hiring a new employee, each employer in Colorado shall affirm that the employer has examined the legal work status of such newly-hired employee and has retained file copies of the documents required by 8 U.S.C. sec. 1324a; that the employer has not altered or falsified the employee's identification documents; and that the employer has not knowingly hired an unauthorized alien. The employer shall keep a written or electronic copy of the affirmation, and of the documents required by 8 U.S.C. sec. 1324a, for the term of employment of each employee.

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security
E-Verify

Report Prepared: 05/19/2015
Page: 1 of 1

Case Verification Number: 2015139094854TE

Case Information:**Employee Information:**

Last Name:	Linan	First Name:	Adrin
Middle Initial:	A	Other Names Used:	
Social Security Number:	*** ** 5485	Date of Birth:	12/16/1990
Citizenship Status:	A citizen of the United States	Email Address:	

Document Information:

List B Document:	Driver's license or ID card issued by a U.S. state or outlying possession	List C Document:	Social Security Card
Document Name:	Driver's license	Document State:	Colorado
Driver's License or ID Card Number:		Document Expiration Date:	12/16/2018
Alien Number:		I-94 Number:	

Additional Information:

Hire Date:	05/18/2015	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CMAY1017	Submitted On:	05/19/2015

Initial Case Result:

Case Result: Employment Authorized

Employee Referred to SSA:

Referred By: Referred On:

Case Result from SSA (after SSA Tentative Nonconfirmation):

Case Result: Response Date:

Resubmitted to SSA (after Review and Update Employee Data):

Last Name:	First Name:
Middle Initial:	Other Names Used:
Social Security Number:	Date of Birth:
Resubmitted By:	Resubmitted On:

Case Result from SSA (after Resubmission):

Case Result:

Request Name Review:

Comments: Submitted On:
Submitted By:

Case Result from DHS (after DHS Verification in Process):

Case Result: Response Date:

Employee Referred to DHS:

Referred By: Referred On:

Case Result from DHS (after DHS Tentative Nonconfirmation):

Case Result: Response Date:

Photo Matching Results:

Determination:

Employee Referred to DHS (Additional):

Referred By:

Referred On:

Case Result from DHS (after Additional DHS Tentative Nonconfirmation):

Case Result:

Response Date:

Case Closure:

Closure Statement:

Closed By:

Closed On:

SENSITIVE BUT UNCLASSIFIED



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9

OMB No. 1615-0047
Expires 03/31/2016

► **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)

Last Name (Family Name) <u>Linan</u>		First Name (Given Name) <u>Adrin</u>		Middle Initial <u>A</u>	Other Names Used (if any)	
Address (Street Number and Name) <u>10350 Dover St.</u>		Apt. Number <u>B15</u>	City or Town <u>Westminster</u>		State <u>CO</u>	Zip Code <u>80021</u>
Date of Birth (mm/dd/yyyy) <u>12/16/1990</u>	U.S. Social Security Number <u>523-79-5485</u>		E-mail Address <u>linan.adrin@gmail.com</u>			Telephone Number <u>719-213-6493</u>

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☒ A citizen of the United States
- ☐ A noncitizen national of the United States (See instructions)
- ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

3-D Barcode
Do Not Write in This Space

Signature of Employee: <u>Adrin Linan</u>	Date (mm/dd/yyyy): <u>05/16/2015</u>
---	--------------------------------------

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:		Date (mm/dd/yyyy):	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State [] Zip Code



Employer Completes Next Page



STOP

Employer Completes This Page

STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: <u>Driver's License</u>		Document Title: <u>Social Security Card</u>
Issuing Authority:		Issuing Authority: <u>State of Colorado</u>		Issuing Authority: <u>SSA</u>
Document Number:		Document Number: <u>08 304 0832</u>		Document Number: <u>523 79 5485</u>
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy): <u>12/16/2018</u>		Expiration Date (if any)(mm/dd/yyyy):
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

3-D Barcode
 Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): 05/18/2015 (See instructions for exemptions.)

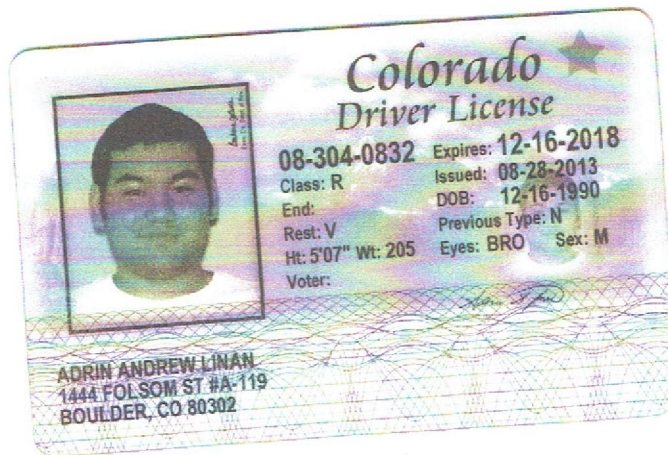
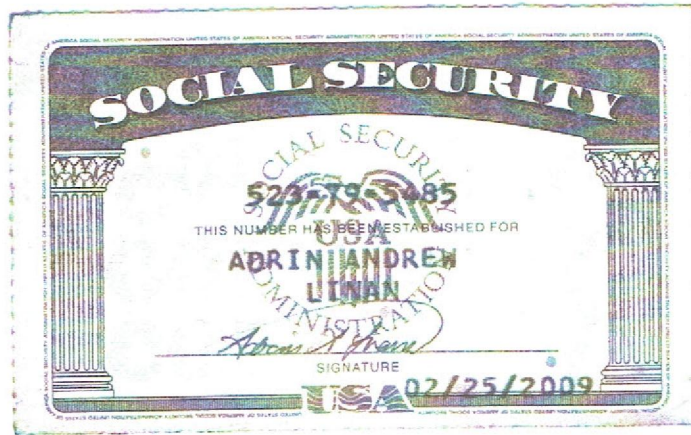
Signature of Employer or Authorized Representative <u>Casey Mayo</u>		Date (mm/dd/yyyy) <u>5/18/2015</u>	Title of Employer or Authorized Representative <u>Account Rep.</u>	
Last Name (Family Name) <u>Mayo</u>		First Name (Given Name) <u>Casey</u>		Employer's Business or Organization Name EMPLOYER SOLUTIONS STAFFING GROUP LLC
Employer's Business or Organization Address (Street Number and Name) 7301 OHMS LANE SUITE 405		City or Town EDINA		State MN
				Zip Code 55439

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial			B. Date of Rehire (if applicable) (mm/dd/yyyy):
C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.			
Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:





Endorsements:

Address Change:

For more information on Organ & Tissue Donation:
www.DonorAlliance.org or Call 888-256-4386

Class R: Any motor vehicle with a GVWR of less than 26,001 lbs. as a single unit or in combination, designed to carry 15 or fewer passengers, including the driver, and does not carry hazardous material.
Restrictions:
V - Corrective Lenses



Social Security Administration
Form SSA-3000 (10-2007)

F 47868296

This card belongs to the Social Security Administration and you must return it if we ask for it.
If you find a card that isn't yours, please return it to:
Social Security Administration
P.O. Box 33008, Baltimore, MD 21290-3008
For any other Social Security business/information, contact your local Social Security office. If you write to the above address for any business other than returning a found card you will not receive a response.

DISCLOSURE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" that may include information about your character, general reputation, personal characteristics, and/or mode of living, and that can involve personal interviews with sources, such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security number validation, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been requested and compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING's website is at www.orangetreescreening.com, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.

New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.

Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel.: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING's website is at: www.orangetreescreening.com, another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by ESSG.

☐ (Must include email address: _____)

Signature: _____ Date: _____

BACKGROUND INFORMATION

Last Name: Linan First: Adrin Middle: Andrew

Other Names/Alias: _____

Social Security #: 523-79-5485 Date of Birth (mm/dd/yyyy)*: 12/16/1990

Driver's License #: 08-304-0832 State of Driver's License: Colorado

Present Address: 10350 Dover St. Apt. B15 Telephone # (Primary): 719-213-6493

City/State/Zip: Westminster, CO 80021

**This information will be used for background screening purposes only and will not be used as hiring criteria.*



"your workforce management & staffing experts"

Criminal Background Check Acknowledgement

Part of the selection process at Corporate Management Group includes a background check. The background check includes the applicant's criminal history. As part of this interview, we ask if the applicant has been convicted of any crime. Whether or not an applicant has been convicted of a crime does not determine applicant's eligibility for this position.

Applicant Name: Adrin Linan Date of Interview: 05/06/15

Recruiter Name: Casey Mayo

Have you ever been convicted of any crime, felony, misdemeanor, not including expunged records?

Yes ☐ No ☒

Is yes, when, where and what was the nature of this offense.

You will not be denied employment solely because you answer "Yes" above or because you have been convicted of a crime, felony or misdemeanor. The company considers many individualized factors in evaluating a job candidate, including but not limited to, with respect to criminal history, the nature and date of any offense, the surrounding circumstances, and the nature of the position for which you apply.

By my signature below, I certify that the information provided above is true and complete that I have discussed the above with my interviewer as disclosed. I understand and agree that any misrepresentation by me will be sufficient cause to eliminate me from consideration for employment and/or terminate employment at any time if I have been employed.

Applicant Signature: Adrin Linan Date: 05/18/15

VSI HR Manager Signature: _____ Eligible: ☐ Ineligible: ☐ Date: _____

EMERGENCY CONTACT INFORMATION

EMPLOYER SOLUTIONS STAFFING GROUP IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION

Employee Name: Adrin Linan

Address: 10350 Dover St. Apt. B15 Westminster, CO 80021

Home Phone: 719-213-6493

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: <u>Amanda Walker</u> Relationship: <u>Fiance</u>	Home Phone: Cell Phone: <u>719-213</u> <u>719-237-9381</u> Work Phone:
Contact #2 Name: <u>Darin Linan</u> Relationship: <u>Father</u>	Home Phone: Cell Phone: <u>719-213-6642</u> Work Phone:

Additional information you want Employer Solutions Staffing Group and our clients to know in the event of an emergency:



employer solutions staffing group^{llc}

Leveraging Resources in a Changing Market

Direct Deposit/Payroll Debit Card Authorization

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card.

If you do not provide a written election, wages will be paid by Payroll Debit Card.

SECTION 1 BASIC INFORMATION			
Employee Name <u>Adrin Linan</u>		SSN# (last 4 digits) <u>5485</u>	Effective Date <u>05/18/15</u>
SECTION 2 PAYROLL ELECTION			
☒ Direct Deposit (Please complete Sections 3 and 5 below) ☐ Payroll Debit Card (Please complete Sections 4 and 5 below)			
SECTION 3 DIRECT DEPOSIT			
A C C O U N T	☐ Update Bank Account		
	Bank Name: <u>Wells Fargo</u>		
	Routing# <u>102000076</u>		
	Account# <u>1993116734</u>		
	Account Type: ☒ Checking ☐ Savings ☐ Other _____		
I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect. Initial <u>AL</u> Date <u>05/18/15</u>			
- To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work) - If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.			
SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)			
Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity. Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.			
CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)			
First Name _____		M.I. _____	Last Name _____
Street Address (PO BOX NOT ACCEPTABLE) _____		Date of Birth _____	
City _____		State _____	Zip _____
Cell Phone (mobile) _____		Social Security# _____	
RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)			
Payroll Debit Card Routing # <u>073972181</u>		Payroll Debit Card Account # _____	
I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.			
Employee's Signature: _____		Date: _____	
SECTION 5 AUTHORIZATION			
I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s). * E-mail is required for pay stub information.			
*E-mail: <u>linan.adrin@gmail.com</u> this information will only be used to send your paystubs electronically			
Employee's Signature: <u>Adrin Linan</u>		Date: <u>05/18/15</u>	

Direct Deposit - Get Paid Faster!
To set up or change your Direct Deposit:

- ✓ Find your new Routing Number (RTN) and Account Number located below
- ✓ Provide this information to your employer/payor

Pay to the Order of Direct Deposit to My Wells Fargo Account Today!! Date \$ My Net Pay

Saves me time and money - one less errand to run! Dollars



Wells Fargo Bank, N.A.
Colorado
wellsfargo.com



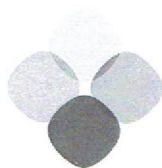
Security
Details on
back

SAMPLE

For Routing Number (RTN) Account Number Free...Fast...Easy...Convenient MP

1020000761

1993118734



employer solutions staffing group^{LLC}

Leveraging Resources in a Changing Market

STATEMENT OF CONFIDENTIALITY

This agreement made this 18 day of May, 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Adrian Lohan hereafter referred to as "employee".

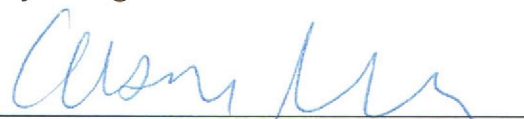
WITNESSETH:

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of \$10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.



Employee Signature



Employer Solutions Staffing Group LLC, Representative

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

OMB No. 1545-1500

► See separate instructions.

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name Adrian Llanan Social security number ► 523-79-5488

Street address where you live 10350 Dover St. Apt. B15

City or town, state, and ZIP code Westminster, CO 80021

County Broomfield Telephone number 719-213-6493

If you are under age 40, enter your date of birth (month, day, year) 12/16/1990

- 1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a Received SNAP benefits (food stamps) for the past 6 months, **or**
 - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months, **or**
 - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► Adrian Llanan

Date 05/18/15

EMPLOYER SECTION:

ESG FEIN#:	ESG Client Name & State:	
Hiring Manager:	Position:	Starting Wage: \$

EMPLOYEE SECTION:

Employee Name: <u>Adrian Linan</u>	Street Address: <u>10350 Dover St. Apt. B15</u>	City/State: <u>Westminster, CO</u>	Zip: <u>80021</u>
SS#: <u>523-79-5485</u>	Date of Birth: <u>12/16/1990</u>	Age: <u>24</u>	Have you worked for this company before? ☐ Yes ☒ No
If yes, location:			

Please complete all questions, and sign and date the form.

	Yes	No
1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	☐	☒
2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	☐	☒
3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. <i>*If you checked yes please provide a copy of your SSI documentation.</i>	☐	☒
4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below: ☐ Vocational Rehabilitation Agency ☐ Dept. of Veterans Affairs ☐ Employment Network (Ticket to Work Program) Name of Agency: _____ Phone #: _____ City: _____ County: _____ State: _____ <i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i>	☐	☒
5. Are you a Veteran of the U.S. Military? <i>*If yes, please provide a copy of your DD-214 and letter of separation.</i> (If yes, please provide information below. If no, please continue to question #6.) Dates of Service - From: ____/____/____ To: ____/____/____ Branch of Service: _____ Are you entitled to or are you receiving compensation for a service-connected disability? ☐ Have you been unemployed at any time during the last 12 months? ☐ If yes, dates of unemployment - From: ____/____/____ To: ____/____/____ Did you receive unemployment compensation at any point during your unemployment? ☐	☐	☒
6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Conviction Date: ____/____/____ Release Date: ____/____/____ Was this a ☐ Federal or ☐ State conviction? If State - County: _____ State: _____	☐	☒

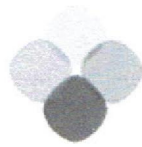
Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe? <i>*If you checked yes please provide a copy of your CDIB card.</i>	☐	☒
CA Residents: ☐ Are you the child of foster parents? ☐ Do you receive CalWorks? ☐ Workforce Investment Act?		
☐ Are you a migrant or seasonal farm worker? ☐ Have you ever been convicted of a misdemeanor?		
SC Residents: ☐ Do you receive Family Independence Benefits?		

PLEASE READ, SIGN, AND DATE:

Under penalties of perjury, I declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. dba Retrotax), or the Department of Labor.

New Employee Signature: Adrian LinanDate: 5/14/15



employer solutions staffing group^{LLC}
Leveraging Resources in a Changing Market

INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

Notify your employer immediately of any new injuries or conditions that impact your physical condition.

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

I have read my responsibilities and agree to abide by these guidelines.

Signed: 

Printed Name: Adrin Linan



employer solutions staffing group^{llc}

Leveraging Resources in a Changing Market

Important/Importante

LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between \$25-\$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the policy report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Adrian Linan

Signature/Firma: 

ENROLLMENT FORM

ESC NAV*SAD P2M v15.0

REQUIRED EMPLOYEE INFORMATION**PRINT USING BLACK or BLUE INK
(Must Be Filled Out)**Social Security Number 523-79-5485Date of Birth 12/16/1990 Sex ☒ M ☐ FName Adrin LinanStreet Address 10350 Dover St. Apt. B15City Westminster State CO Zip 80021Home Phone 719-213-6493

Do you or any dependents have Medicare?

☐ Yes ☒ No If Yes:Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date ____/____/____

Names of Covered Person(s)

1. _____

2. _____

3. _____

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex ☐ M ☐ FRelationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name _____

Social Security Number _____

Date of Birth ____/____/____ Sex ☐ M ☐ FRelationship: ☐ Spouse ☐ Child ☐ Domestic Partner**BENEFICIARY INFORMATION**

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARYAmanda Walker**RELATIONSHIP**Fiance

Accidental Death & Dismemberment is part of the Term Life Benefit.

OPTION 1**FIXED INDEMNITY PLAN**

Weekly Rates

You MUST enroll in the Indemnity Medical Insurance Plan before adding any additional Indemnity benefits, except Dental. Your coverage level for the Term Life will be identical to your medical plan selection.

FIXED INDEMNITY MEDICAL☐ \$20.91 Employee Only☐ \$42.44 Employee + 1☐ \$56.67 Employee + Family☒ **NO to all Indemnity benefits.**

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL☐ \$5.99 Employee Only☐ \$11.98 Employee + 1☐ \$19.77 Employee + Family☒ **NO****TERM LIFE**☐ **YES** \$0.60 Employee Only☐ \$0.90 Employee + 1☒ **NO** \$1.80 Employee + Family**SHORT-TERM DISABILITY**☐ **YES**☒ **NO** \$4.20 Employee Only

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

OPTION 2

82193010-M-EMP

MEC WELLNESS/PREVENTIVE PLAN

Monthly Rates

☐ \$58.87 Employee Only☐ \$87.73 Employee+ 1☐ \$186.99 Employee + Family☒ **NO to MEC Wellness/Preventive Plan**

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

Signature Adrian LinanDate 12/16/1990