

**SENSITIVE BUT UNCLASSIFIED****Department of Homeland Security****Report Prepared: 01/14/2015****E-Verify****Page: 1 of 1****Case Verification Number: 2015014151558TT****Case Information:****Employee Information:**

|                         |                                |                   |            |
|-------------------------|--------------------------------|-------------------|------------|
| Last Name:              | Johnson                        | First Name:       | Dallas     |
| Middle Initial:         |                                | Other Names Used: |            |
| Social Security Number: | *** ** 3117                    | Date of Birth:    | 02/08/1990 |
| 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:          | U.S. birth certificate (original or certified copy) |
| Document Name:                      | Driver's license                                                          | Document State:           | Minnesota                                           |
| Driver's License or ID Card Number: |                                                                           | Document Expiration Date: | 02/08/2015                                          |
| Alien Number:                       |                                                                           | I-94 Number:              |                                                     |

**Additional Information:**

|                        |            |                         |            |
|------------------------|------------|-------------------------|------------|
| Hire Date:             | 01/14/2015 | Employer Case ID:       |            |
| Three-Day Rule Reason: |            | Three-Day Rule - Other: |            |
| Submitted By:          | ESAG6409   | Submitted On:           | 01/14/2015 |

**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 By: | Submitted On: |

**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: | The employee continues to work for the employer after receiving an Employment Authorized result. |            |            |
| Closed By:         | ESAG6409                                                                                         | Closed On: | 01/14/2015 |

**SENSITIVE BUT UNCLASSIFIED**

00287

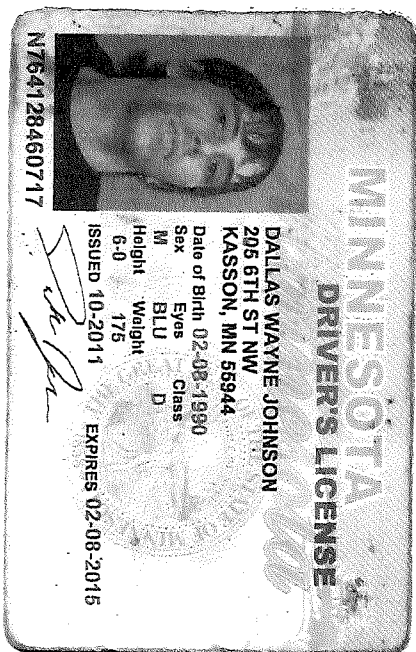
MINNESOTA DEPARTMENT OF HEALTH  
SECTION OF VITAL STATISTICS  
CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER

STATE FILE NUMBER

PARENTS WANT SOCIAL SECURITY  
NUMBER FOR CHILD? ☐ YES ☒ NOTYPE/PRINT IN PERMANENT BLACK INK.  
FOR INSTRUCTIONS, SEE HANDBOOK.

|                                                                                                                                                                                                                              |  |                                                            |                                       |                                                                                                                                                                                                                |  |                                                              |  |                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|---------------------------------------|--|
| 1. CHILD'S NAME (First)<br><b>Dallas</b>                                                                                                                                                                                     |  | (Middle)<br><b>Wayne</b>                                   |                                       | (Last)<br><b>Johnson</b>                                                                                                                                                                                       |  | 2. DATE OF BIRTH (Month, Day, Year)<br><b>2 8 90</b>         |  | 3. TIME OF BIRTH<br><b>9:03 A. M.</b> |  |
| 4. SEX<br><b>Male</b>                                                                                                                                                                                                        |  | 5. PLURALITY: Single, twin, triplet, etc.<br><b>Single</b> |                                       | 6. IF NOT SINGLE BIRTH: Born First, Second, Third, etc.<br>(Specify)                                                                                                                                           |  | 7. COUNTY OF BIRTH<br><b>Olmsted</b>                         |  |                                       |  |
| 8. CITY OR TOWNSHIP OF BIRTH<br><b>Rochester</b>                                                                                                                                                                             |  |                                                            |                                       | 9. PLACE OF BIRTH<br><input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Residence<br><input type="checkbox"/> Free-standing Birthing Center <input type="checkbox"/> Clinic/Doctor's Office |  |                                                              |  |                                       |  |
| 10. FACILITY NAME (If not institution, give street & number)<br><b>Rochester Methodist Hospital</b>                                                                                                                          |  |                                                            |                                       | <input type="checkbox"/> Other (Specify)                                                                                                                                                                       |  |                                                              |  |                                       |  |
| 11. I certify that I attended the birth of this child who was born alive at the place and time and on the date stated.<br><br>Signature: <b>Diana Arlenko-Dixon, MD</b> 12. DATE SIGNED (Month, Day, Year)<br><b>2-10-90</b> |  |                                                            |                                       |                                                                                                                                                                                                                |  |                                                              |  |                                       |  |
| 13. ATTENDANT'S NAME AND TITLE (Type or Print)<br><b>Diana Arlenko-Dixon MD</b> 14. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City, State, Zip Code)<br><b>Mayo Clinic Rochester, MN 55905</b>   |  |                                                            |                                       |                                                                                                                                                                                                                |  |                                                              |  |                                       |  |
| 15. REGISTRAR'S SIGNATURE<br><b>Deborah J. Ristley, Deputy</b> 16. DATE FILED BY REGISTRAR (Month, Day, Year)<br><b>2/15/90</b>                                                                                              |  |                                                            |                                       |                                                                                                                                                                                                                |  |                                                              |  |                                       |  |
| 17a. MOTHER'S PRESENT NAME (First, Middle, Last)<br><b>Bonnie Jo Ristley</b>                                                                                                                                                 |  |                                                            | 17b. MAIDEN SURNAME<br><b>Ristley</b> |                                                                                                                                                                                                                |  | 18. DATE OF BIRTH (Month, Day, Year)<br><b>2 1 67</b>        |  |                                       |  |
| 19. BIRTHPLACE (State or Foreign Country)<br><b>Minnesota</b>                                                                                                                                                                |  | 20a. RESIDENCE OF MOTHER: STATE<br><b>Minnesota</b>        |                                       | 20b. COUNTY<br><b>Goodhue</b>                                                                                                                                                                                  |  | 20c. CITY OR TOWNSHIP<br><b>Wanamingo</b>                    |  |                                       |  |
| 20i. STREET AND NUMBER<br><b>561 Hill Ave.</b>                                                                                                                                                                               |  | 20j. INSIDE CITY LIMITS (Yes or No)<br><b>Yes</b>          |                                       | 21. MOTHER'S MAILING ADDRESS (If same as residence, enter Zip only)<br><b>55903</b>                                                                                                                            |  | 24. BIRTHPLACE (State or Foreign Country)<br><b>Illinois</b> |  |                                       |  |
| 22. FATHER'S NAME (First, Middle, Last)<br><b>Keanen Win Johnson</b>                                                                                                                                                         |  | 23. DATE OF BIRTH (Month, Day, Year)<br><b>9 19 70</b>     |                                       |                                                                                                                                                                                                                |  |                                                              |  |                                       |  |
| 25. I certify that the personal information on this certificate is correct to the best of my knowledge and belief.<br>Signature of Parent: <b>X Thomas J. Ristley</b> THIS SPACE RESERVED FOR USE OF REGISTRAR               |  |                                                            |                                       |                                                                                                                                                                                                                |  |                                                              |  |                                       |  |

STATE OF MINNESOTA  
COUNTY OF OLMTED  
I certify this to be a true copy of  
the original record in my custody.Dated **11-7-90**  
LOIS FURSTEN  
County Recorder**Joan M. Boes**



# 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)<br>JOHNSON                        |                                            | First Name (Given Name)<br>DALLAS |                                              | Middle Initial<br>W | Other Names Used (if any) |                                    |
| Address (Street Number and Name)<br>8210 SALEM RD SW LOTS |                                            | Apt. Number                       | City or Town<br>BYRON                        |                     | State<br>MN               | Zip Code<br>55920                  |
| Date of Birth (mm/dd/yyyy)<br>02/08/1990                  | U.S. Social Security Number<br>176-23-3117 |                                   | E-mail Address<br>dallas.johnson89@gmail.com |                     |                           | Telephone Number<br>(507) 272-5838 |

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: \_\_\_\_\_

3-D Barcode  
Do Not Write in This Space

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)

|                        |                             |
|------------------------|-----------------------------|
| Signature of Employee: | Date (mm/dd/yyyy): 01/14/15 |
|------------------------|-----------------------------|

**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



**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:

Johnson, Dallas W.

| List A<br>Identity and Employment Authorization | OR | List B<br>Identity                                                                                                                                    | AND | List C<br>Employment Authorization    |
|-------------------------------------------------|----|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------|
| Document Title:                                 |    | Document Title:<br>Driver's License                                                                                                                   |     | Document Title:<br>Birth Certificate  |
| Issuing Authority:                              |    | Issuing Authority:<br>Minnesota                                                                                                                       |     | Issuing Authority:<br>Minnesota       |
| Document Number:                                |    | Document Number:<br>N764128460717                                                                                                                     |     | Document Number:<br>00287             |
| Expiration Date (if any)(mm/dd/yyyy):           |    | Expiration Date (if any)(mm/dd/yyyy):<br>2/8/2015                                                                                                     |     | Expiration Date (if any)(mm/dd/yyyy): |
| Document Title:                                 |    | <div style="border: 1px solid black; padding: 10px; text-align: center;"> <b>3-D Barcode</b><br/>           Do Not Write in This Space         </div> |     |                                       |
| Issuing Authority:                              |    |                                                                                                                                                       |     |                                       |
| Document Number:                                |    |                                                                                                                                                       |     |                                       |
| Expiration Date (if any)(mm/dd/yyyy):           |    |                                                                                                                                                       |     |                                       |
| Document Title:                                 |    |                                                                                                                                                       |     |                                       |
| Issuing Authority:                              |    |                                                                                                                                                       |     |                                       |
| Document Number:                                |    |                                                                                                                                                       |     |                                       |
| Expiration Date (if any)(mm/dd/yyyy):           |    |                                                                                                                                                       |     |                                       |

**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): \_\_\_\_\_ (See instructions for exemptions.)

|                                                                                                  |  |                                  |                                                                                   |                   |
|--------------------------------------------------------------------------------------------------|--|----------------------------------|-----------------------------------------------------------------------------------|-------------------|
| Signature of Employer or Authorized Representative<br><i>Emily Therios</i>                       |  | Date (mm/dd/yyyy)<br>1/14/2015   | Title of Employer or Authorized Representative<br>Office Assistant                |                   |
| Last Name (Family Name)<br>Therios                                                               |  | First Name (Given Name)<br>Emily | Employer's Business or Organization Name<br>EMPLOYER SOLUTIONS STAFFING GROUP LLC |                   |
| Employer's Business or Organization Address (Street Number and Name)<br>7301 OHMS LANE SUITE 405 |  | City or Town<br>EDINA            | State<br>MN                                                                       | Zip Code<br>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: |
|                                                     |                    |                                                      |

**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](http://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](http://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: 01/14/15

**BACKGROUND INFORMATION**

Last Name: JOHNSON

First: DALLAS

Middle: JOHNSON

Other Names/Alias: \_\_\_\_\_

Social Security #: 176-23-3117

Date of Birth (mm/dd/yyyy)\*: 02/08/1990

Driver's License #: N764

State of Driver's License: MINNESOTA

Present Address: 8210 SALEM RD SW LOTS Telephone # (Primary): (507) 272-5838

City/State/Zip: BUROU/MN/55920

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

# 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](http://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: <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>                                                                                                                                                                                                                                                 | 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 (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) . . . . .                                                                                                                                                                                                                                                                                                                 | F | _____    |
| G | Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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 . . . . .</li> </ul> | 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                                                                                                                                                                                                                                                                                                                                                                                                              | 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 <b>W-4</b><br>Department of the Treasury<br>Internal Revenue Service                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Employee's Withholding Allowance Certificate</b> | OMB No. 1545-0074<br><b>2015</b>                                                                                                                                                                                                                          |
| > 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.                                                                                                                                                                                                                                                                            |                                                     |                                                                                                                                                                                                                                                           |
| 1 Your first name and middle initial<br><u>Dallas W</u>                                                                                                                                                                                                                                                                                                                                                                                                                            | Last name<br><u>Johnson</u>                         | 2 Your social security number<br><u>476-23-3117</u>                                                                                                                                                                                                       |
| Home address (number and street or rural route)<br><u>8210 Salem rd sw lot 5</u>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                     | 3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate.<br>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |
| City or town, state, and ZIP code<br><u>Byron MN 55920</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. > <input type="checkbox"/>                                                                                     |
| 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 \$ _____                                          |                                                                                                                                                                                                                                                           |
| 7 I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> 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<br>(This form is not valid unless you sign it.) > <u>Dallas Johnson</u>                                                                                                                                                                                                                                                                                                                                                                                       |                                                     | Date > <u>1/15/15</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)                                                                                                                                                                                                                   |



employer solutions staffing group llc  
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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 JOHNSON First Name DALLAS Middle Initial W  
Street Address 8210 SALEM RD SW LOT 5 Apt/Ste \_\_\_\_\_  
City/State/Zip BYRON, MN, 55920  
Phone Number (507) 772-5838 Email Address dallasjohnson89@gmail.com  
Staffing Agency/Recruitment Partner ESSG/RF

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.

DALLAS JOHNSON  
Name (Print or type)

[Signature]  
Applicant's Signature

1/15/15  
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<br>_____ | Background Release Form<br>_____ | Background Results<br>_____ | Unemployment Letter<br>(If applicable)<br>_____ | ESC Application<br>_____ |

### For ESSG Client Use

|           |           |                      |               |
|-----------|-----------|----------------------|---------------|
| DOH _____ | ROP _____ | Work Site Loc. _____ | WC Code _____ |
|-----------|-----------|----------------------|---------------|

## EMERGENCY CONTACT INFORMATION

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

Employee Name: Dallas Johnson  
Address: 8210 solem rd sw lot 5  
Home Phone: (507) 272-5838

| EMERGENCY CONTACTS                                                                        |                                                                                                                                 |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| Please list two people (in priority order) who could be contacted in case of an emergency |                                                                                                                                 |
| <b>Contact #1</b><br><br>Name: <u>Bonnie Johnson</u><br><br>Relationship: <u>Mother</u>   | Home Phone: <u>                    </u><br><br>Cell Phone: <u>(507) 272-5838</u><br><br>Work Phone: <u>                    </u> |
| <b>Contact #2</b><br><br>Name:<br><br>Relationship:<br><br>                               | Home Phone:<br><br>Cell Phone:<br><br>Work Phone:<br><br>                                                                       |

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

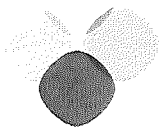
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## STATEMENT OF CONFIDENTIALITY

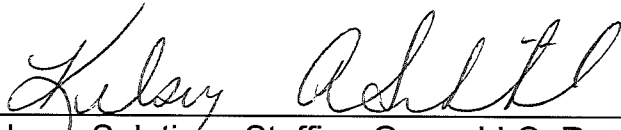
This agreement made this 15 day of Jan, 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Dallas Johnson hereafter referred to as "employee".

### **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 Dallas Johnson Social security number ► 176-23-3117  
Street address where you live 8210 Salem rd sw Lot 5  
City or town, state, and ZIP code Byron MN 55920  
County Olmsted Telephone number (507) 272-5838  
If you are under age 40, enter your date of birth (month, day, year) 2/8/90

- 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 ► *Dallas Johnson*

Date 1/15/15

## EMPLOYER SECTION:

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

## EMPLOYEE SECTION:

|                                         |                                  |                                                 |                                                                                                                 |                             |                      |
|-----------------------------------------|----------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------|
| Employee Name:<br><u>Dallas Johnson</u> |                                  | Street Address:<br><u>8210 Salem rd sw lots</u> |                                                                                                                 | City/State:<br><u>Byron</u> | Zip:<br><u>55920</u> |
| SS#: <u>476-23-3117</u>                 | Date of Birth: <u>02/08/1996</u> | Age: <u>24</u>                                  | Have you worked for this company before?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.)<br>Name of the person receiving benefits: _____ Relationship to you: _____<br>City: _____ County: _____ State: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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.)<br>Name of the person receiving benefits: _____ Relationship to you: _____<br>City: _____ County: _____ State: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?<br>Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits.<br>*If you checked yes please provide a copy of your SSI documentation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you received any type of vocational rehabilitation services within the past two years?<br>If yes, please indicate which type of agency you worked with and provide their location information below:<br><input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program)<br>Name of Agency: _____ Phone #: _____<br>City: _____ County: _____ State: _____<br>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.                                                                                                                                                                                  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are you a Veteran of the U.S. Military? *If yes, please provide a copy of your DD-214 and letter of separation.<br>(If yes, please provide information below. If no, please continue to question #6.)<br>Dates of Service - From: ____/____/____ To: ____/____/____<br>Branch of Service: _____<br>Are you entitled to or are you receiving compensation for a service-connected disability? <input type="checkbox"/> <input type="checkbox"/><br>Have you been unemployed at any time during the last 12 months? <input type="checkbox"/> <input type="checkbox"/><br>If yes, dates of unemployment - From: ____/____/____ To: ____/____/____<br>Did you receive unemployment compensation at any point during your unemployment? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?<br>Conviction Date: ____/____/____ Release Date: ____/____/____<br>Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

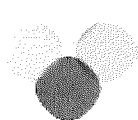
## Additional Tax Credits

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

## 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: *Dale Johnson* Date: 1/15/15



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## 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: Dallas Johnson



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## 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 police 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): Dallas Johnson

Signature/Firma: 



## New Employee Acknowledgement Form

Welcome to CMG and Reichel Foods!

As a new employee, you will be provided with copies of documents or items listed below. Please initial each line when you receive that particular document or item. Please sign and date the bottom of the sheet when all documents or items have been distributed to you.

CMG/Reichel Foods Handbook

-Attendance Policy page 6

-Time off Request procedure page 20

-No Smoking Policy, Edg. Chewing policy page 12

- Final Paycheck at Time of Separation page 18

Receipt of Unemployment Acknowledgement

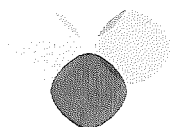
DI  
DI  
DI  
DI  
DI

I hereby acknowledge that I have been provided with each and every item listed above, that it is my responsibility to read and follow each document provided to me and that if I have any questions concerning the item or its content then it is my responsibility to address my questions with my supervisor or CMG, and hereby waive any claim, now or in the future, that I did not receive, did not read or did not comprehend the items or their contents.

Dated: 1/15/15

Signature: *Dallas Johnson*

(Printed Name) DALLAS JOHNSON



employer solutions staffing group<sup>LLC</sup>

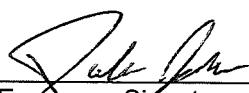
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**Notification of Minnesota Law Requirement –**  
**Unemployment Acknowledgement**

*According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment.*

It is your responsibility to contact ESSG (for instance, by calling (507) 398.4567 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. DA (Initial)

  
Employee Signature:

1/15/15  
Date:

DALLAS JOHNSON  
Employee (please print your name here)

### Acknowledgement of Receipt Antiharassment Policy

I certify that I have received a copy of Employer Solutions Staffing Group's Antiharassment Policy. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at **952.835.1288/1.866.496.7573** with any questions I may have about this policy. I agree to comply with ESSG's policy on Antiharassment and understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am involved in any employment dispute or I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, marital, sexual orientation or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact my supervisor, manager, director or ESSG's Human Resource Department at **952.835.1288/1.866.496.7573** in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

DALLAS JOHNSON

Employee's Signature:

[Signature]

Date: 1/15/15

## RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT

This is to acknowledge that I have read the Employer Solutions Staffing Group LLC Temporary Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities and obligations of my employment with the company. I understand and agree that it is my responsibility to abide by the rules, policies and standards set forth in the Handbook.

I also acknowledge that my employment with ESSG is not for a specified period of time and can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no manager or employee has the authority to enter into an employment agreement, express or implied, providing for employment other than at-will.

I also acknowledge that, except for the policy of at-will employment, ESSG reserves the right to revise, delete and add to the provisions of this Employee Handbook. All such revisions, deletions or additions must be in writing and must be signed by the CEO of the company. No oral statements or representations can change the provisions of this Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company, with or without cause or notice, at any time. No implied contract concerning any employment-related decision, term of employment or condition of employment can be established by any other statement, conduct, policy or practice.

I understand the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and ESSG concerning the duration of my employment, the circumstances under which my employment may be terminated and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings and representations concerning my employment with the company.

If I have questions regarding the content or interpretation of this Handbook, I will bring them to the attention of ESSG.

DATE 1/15/15

EMPLOYEE  
NAME DALLAS JOHNSON  
PLEASE PRINT

EMPLOYEE  
SIGNATURE [Signature]

ESSG  
REPRESENTATIVE [Signature]



## ACKNOWLEDGMENT

The associate handbook was reviewed with me, and I have received my personal copy. I also acknowledge that I have been given the opportunity to ask questions and express concerns during my orientation. Additionally, I understand and support the following:

1. This handbook is intended as a guide and **not** an employment agreement that creates a contractual relationship, and that the employment relationship may be terminated at the will of either party at any time.
2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.
3. I agree to **notify** my CMG/ESSG Consultant **immediately** of any change in my personal data such as phone number, address, emergency notification, etc.
4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my CMG/ESSG Consultant.

Date:

1/15/15

Associate's Signature:

[Signature]

Associate's Printed Name:

Dallas Johnson

Orientation provided by:

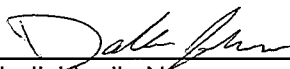
[Signature]

**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

  
\_\_\_\_\_  
Individual's Name

6/14/15  
\_\_\_\_\_  
Date

**SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6**