



# Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name CLARK First Name MICHAEL Middle Initial J  
 Street Address 303 Greenwich Avenue Apt/Ste A115  
 City/State/Zip Warwick, Rhode Island 02886  
 Phone Number 631-830-5418 Email Address Michael.J.Clark@gmail.com  
 Staffing Agency/Recruitment Partner \_\_\_\_\_

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.

Michael J. Clark  1/5/14  
 Name (Print or type) Applicant's Signature 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 _____	8860 _____	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 _____	

1 2 3 4 5 6 7 8 9 10 11 12

Part I

1. Name of the organization
2. EIN
3. State
4. Year
5. Form type
6. Filing date
7. Preparer name
8. Preparer EIN
9. Preparer address
10. Preparer phone
11. Preparer fax
12. Preparer email

Part II

13. Total revenue
14. Total expenses
15. Total assets
16. Total liabilities
17. Total net assets
18. Total net income
19. Total net loss
20. Total net change in net assets

Part III

21. Total revenue
22. Total expenses
23. Total assets
24. Total liabilities
25. Total net assets
26. Total net income
27. Total net loss
28. Total net change in net assets

Part IV

Table with 2 columns: Description, Amount. Rows include: Total revenue, Total expenses, Total assets, Total liabilities, Total net assets, Total net income, Total net loss, Total net change in net assets.

29. Total revenue
30. Total expenses
31. Total assets
32. Total liabilities
33. Total net assets
34. Total net income
35. Total net loss
36. Total net change in net assets

W-4

2014

2014

Form with various fields and checkboxes for reporting purposes.

**State of Rhode Island and Providence Plantations  
Employee's Withholding Allowance Certificate**

If you have more than one job or your spouse works, you should figure the total number of allowances you are entitled to claim. Your withholding usually will be more accurate if you claim all of your allowances on the Form RI W-4 for the highest-paying job and claim zero on all of your other RI W-4 forms. You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld. Also, keep in mind that based on the new personal income tax system in effect as of January 1, 2011, if your annual wages exceed \$207,950, your exemption amount will be phased out and be equal to zero.

**Line 1: Figure your personal allowances (including allowances for dependents)**

- A. No one else can claim me as a dependent. If yes, enter "1" on line 1A..... 1A. 0 B.
- I can claim my spouse as a dependent. If yes, enter "1" on line 1B..... 1B. 0
- C. Enter the number of dependents (other than you or your spouse) you will claim on your tax return..... 1C. 0
- D. Enter any additional allowances (review carefully to avoid underwithholding) ..... 1D. 0
- E. Add lines A, B, C and D and enter here. However, if line E is more than 10, enter 10.  
This is the total number of personal allowances to which you are entitled. Enter on line 1 below..... 1E. 0

**Line 2: Additional withholding amounts**

If you want additional withholding taken out of your pay, enter that dollar amount which is to be withheld each pay period on line 2 below.

**Line 3: Exempt Taxpayer**

**Exempt Status #1**

If you meet both of the conditions below, you may claim exemption from Rhode Island withholding for 2013:

- a) Last year I had a right to a refund of all Rhode Island income tax withheld because I had no tax liability AND
- b) This year I expect a refund of all Rhode Island income tax because I expect to have no tax liability. If you meet both of the above conditions, write "EXEMPT" on line 3 below.

**Exempt Status #2**

If you are the spouse of a servicemember stationed in Rhode Island, your wages may be exempt under the Military Spouses Residency Relief Act. If you meet both of the conditions below, you may claim exemption from Rhode Island withholding for 2013.

- a) You moved to Rhode Island solely to be with your servicemember spouse in compliance with military orders sending the servicemember to Rhode Island AND
- b) You have the same non-Rhode Island domicile as your servicemember spouse.

If you meet both of the above conditions, write "EXEMPT-MS" on line 3 below.

**NOTE:**  
If you claim "EXEMPT" or "EXEMPT-MS" on line 3, you must complete Form RI W-4 each year. Otherwise, Form RI W-4 only needs to be completed if you are making changes to your withholding allowance.



# 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** (Employee 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) <b>CLARK</b>		First Name (Given Name) <b>MICHAEL</b>		Middle Initial <b>JAMES</b>	Other Names Used (If any)	
Address (Street Number and Name) <b>303 Greenwich Avenue</b>			Apt. Number <b>A115</b>	City or Town <b>Klarwick</b>	State <b>RI</b>	Zip Code <b>02884</b>
Date of Birth (mm/dd/yyyy) <b>05/12/1981</b>	U.S. Social Security Number <b>0167-7127457</b>		E-mail Address <b>Michael.J.Clark@gmail.com</b>		Telephone Number <b>(631) 830.5418</b>	

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): <b>VS/14</b>
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**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): _____
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Last Name (Family Name)	First Name (Given Name)
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## 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 License</u>		Document Title: <u>Birth Certificate</u>
Issuing Authority:		Issuing Authority: <u>NY</u>		Issuing Authority: <u>NY</u>
Document Number:		Document Number: <u>956-540-247</u>		Document Number:
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy): <u>5.12.18</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): 1-8-14 (See instructions for exemptions.)

Signature of Employer or Authorized Representative <u>[Signature]</u>		Date (mm/dd/yyyy) <u>1.13.14</u>	Title of Employer or Authorized Representative <u>Acct Mgr</u>	
Last Name (Family Name) <u>hsol</u>		First Name (Given Name) <u>Tina</u>		Employer's Business or Organization Name
Employer's Business or Organization Address (Street Number and Name)			City or Town	State      Zip Code

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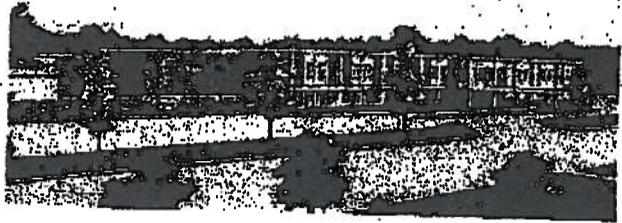
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

PATCHOGUE, L.I., NEW YORK

## Certificate of Birth



This Certifies that Michael James Clark

was born to Deborah & Edward Dominic Clark

in this Hospital

at 10:15 m on Tuesday the 12th day of May 19 81

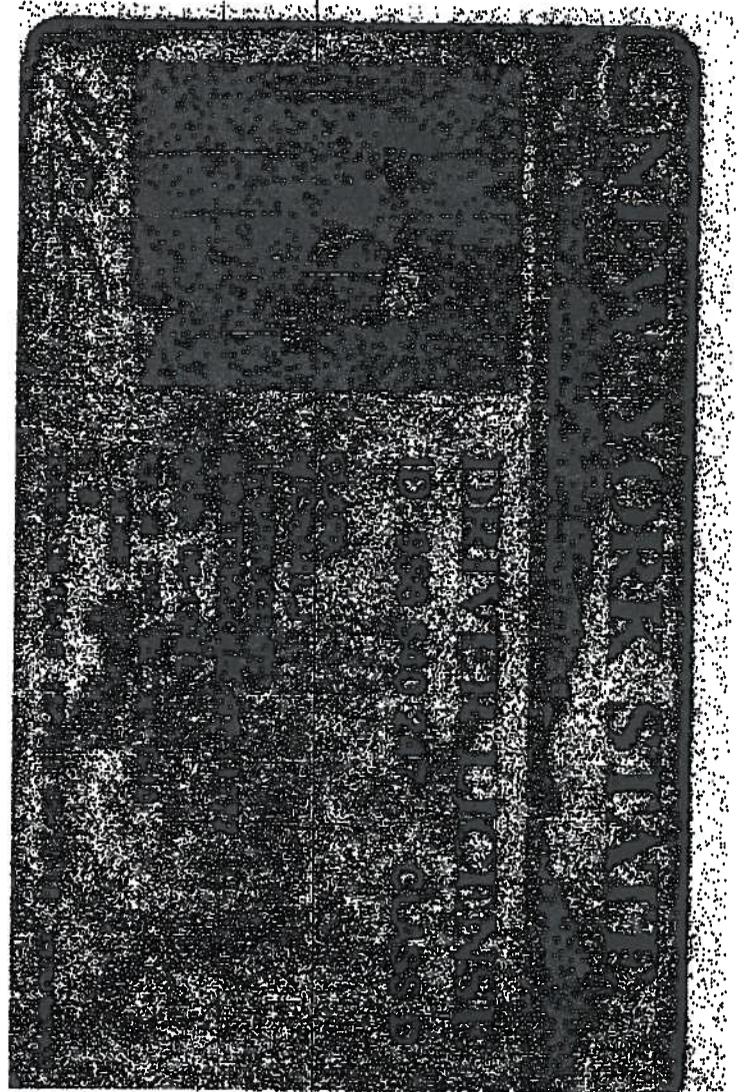
IN WITNESS WHEREOF the said Hospital has caused  
this Certificate to be signed by its duly authorized Officer  
and its Official Seal to be hereunto affixed.

ATTENDING PHYSICIAN

ADMINISTRATOR



*Michael James Clark*



**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.

<small>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.</small>
<small>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.</small>
<small>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.</small>
<small>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.</small>

**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: Michael . J. Clark @ gmail . com,

Signature:  Date: 1/5/14

Last Name: CLARK First: MICHAEL Middle: JAMES

Other Names/Alias: \_\_\_\_\_  
 Social Security #: 067 22 7457 Date of Birth (mm/dd/yyyy): 05-12-1981

Driver's License #: \_\_\_\_\_ State of Driver's License: New York

Present Address: 303 Greenwich Ave. Telephone # (Primary): 631.830.5418

City/State/Zip: Warwick RI. 02886

- Identity theft victims and active duty military personnel have additional rights. For more information, visit [www.consumerfinance.gov/learnmore](http://www.consumerfinance.gov/learnmore) Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

## EMERGENCY CONTACT INFORMATION

<b>EMPLOYER SOLUTIONS STAFFING GROUP</b> <b>IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION</b>
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Employee Name: Michael J. Clark  
 Address: 303 Greenwich Avenue, Warwick RI 02886  
 Home Phone: 631.830.5418

<small>Please do not provide emergency contact information to anyone other than the designated emergency contact.</small>		
<b>Contact #1</b>  Name: <u>Amrita Clark</u>  Relationship: <u>Spouse</u>		Home Phone: <u>917 683 9192</u>  Cell Phone:  Work Phone: <u>401.270.7095</u>
<b>Contact #2</b>  Name: <u>Edward Clark</u>  Relationship: <u>Parent.</u>		Home Phone: <u>631.289.4152</u>  Cell Phone:  Work Phone:

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

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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.

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)LUVW1DPH 0, /DVW1DPH DWHRF%LUWK  
6WUHHW\$GGUHV32962,127846(37596)  
6RFLD06HFXXULWA  
&LWA 6WDWH =LS Cell3KRQH (mobile)

GET TEXT ALERTS, when your paycheck is deposited on your card!  Yes, sign me up, for text alerts  
All we need to know your cell phone service provider and mobile number above! My mobile service provider is:

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3DUROO'HELW&DUGSRXWLQJ 3DUROO'HELW&DUG\$FFRXQW  
122242597

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YDWLQJ3DUROO'HELW&DUG  
,DPDJUHLQJWRWKHSURJUDPWHPVFRQGLWLRQVDQGGGLVFORVXUHVWKDWDUHLQFOXGHGRUPDGEDYDLODEOHWRPHEURFWLPHW  
RWLPHIURPWKHILQDQFLDOLQVWLWXWLRQ  
DXWKRULJHWHKHLQDQFLDOLQVWLWXWLRQWRGHEHLP3DUROO'HELW&DUGDFFRXQWIRUWKHHRVGHVVFULEHGLQWKHHRVFKHG  
XOHWKDWLVSDUWRIWKHSURJUDPWHPV  
FRQGLWLRQVDQGGGLVFORVXUHV

(PSORVHFV6LJQDWXUH DWH

DXWKRULJH(66\*WRGLUHFWOAGHSRVLWPSHULRGLFZDJHVFRPSSHQVDWLRQSDPHQVQHWRIUHTXLUHGWDJZLWKKROGLQJV  
RWKHUHTXLUHGZLWKKROGLQJV  
RUDXWKRULJHGGHGXFWLRQVLDQWRP'DFFRXQWVDVGHVLIQDWHGDERYHDQGWRLQLWLDWHLIQHFHVVDUGHELWHQWULH  
VDQGDGMXVWPHQWVIRUDQFUHGLWHQWULHV PDGHLQHURUWRP'DFFRXQWV  
(PDLOLVUHTXLUHGIRUSDVWXELQIRUPDWLRQ

(PDLO @

\_\_\_\_\_ this information will only be used to send your paystubs electronically \_\_\_\_\_

Employee's Signature:

Date:



**employer solutions staffing group**  
Leveraging Resources in a Changing Market

**STATEMENT OF CONFIDENTIALITY**

This agreement made this 5 day of January, 2014, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and 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

NAME [?][?][?]
ADDRESS
CITY AND STATE
EMPLOYEE NUMBER

EMPLOYER SOLUTIONS STAFFING GROUP LLC

12345 67890 1234567890 1234567890

DATE

EMPLOYEE NUMBER

THE UNDERSIGNED AGREE TO THE ABOVE TERMS AND CONDITIONS SET FORTH ONLY BECAUSE OF THE FACTS SET FORTH

REG DATE

REGISTRATION NUMBER

REGISTRATION NUMBER

REGISTRATION NUMBER

REGISTRATION NUMBER

REGISTRATION NUMBER

- 1. I understand that the above information is being used for the purpose of...
2. I understand that the above information is being used for the purpose of...
3. I understand that the above information is being used for the purpose of...
4. I understand that the above information is being used for the purpose of...
5. I understand that the above information is being used for the purpose of...
6. I understand that the above information is being used for the purpose of...
7. I understand that the above information is being used for the purpose of...
8. I understand that the above information is being used for the purpose of...
9. I understand that the above information is being used for the purpose of...
10. I understand that the above information is being used for the purpose of...



Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. \*If you checked yes please provide a copy of your SSI documentation.

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: \_\_\_\_\_

\*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.

5. Are you a Veteran of the U.S. Military? \*If yes, please provide a copy of your DD-214 and letter of separation.

(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?

\*If you checked yes please provide a copy of your CDIB card.

CA Residents: Are you the child of foster parents? Do you receive CalWorks? Workforce Investment Act?

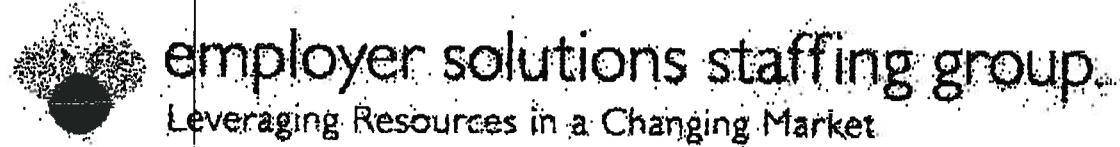
Are you a migrant or seasonal farm worker? Have you ever been convicted of a misdemeanor?

SC Residents: Do you receive Family Independence Benefits?

PLEASE READ, SIGN, AND DATE:

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: \_\_\_\_\_ Date: 1/5/14



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.

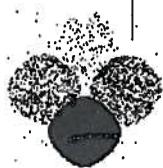
If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

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

Signed: \_\_\_\_\_

Printed Name: Michael Clark

2



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 reissue 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):

Michael Clark

Signature/Firma:

Employee Keeps This Form

New Health Insurance Marketplace Coverage  
Options and Your Health Coverage

Form Approved  
1210-0149  
(Rev. 11-30-2013)



### PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?