CMG APPLICATION FOR EMPLOYMENT

APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS AND A BACKGROUND CHECK WILL BE COMPLETED

PLEASE COMPLETE PAGES 1-5 DATE 4/5/13

Name Ward Christina J
Last First Middle Maiden

Present address 1027 E. 9th Ave #102
Number Street
Broomfield CO 80020
City State Zip

Social Security No. 521-93-2139

Telephone (720) 474-2584 E-Mail Ciward94@yahoo.com

If under 18, please list age _____ Referred by _____

Position applied for (1) _____
and salary desired (2) _____
(Be specific)

Shift available to work
1st X
2nd _____
3rd _____

How many hours can you work weekly? Open Can you work nights? NO (no transportation)

Employment desired X FULL-TIME ONLY ___ PART-TIME ONLY ___ FULL- OR PART-TIME

When available for work? ~~Now~~ ASAP

Do you have responsibilities or commitments that will prevent you from meeting specified work schedules?
___ No X Yes If so, please explain Doctor's Appts. & meetings w/ my caseworker

Do you anticipate any absences from work on a regular basis?
X No ___ Yes If so, please explain _____

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete mailing address)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School	Joan Farley Academy	Denver, CO	1	Diploma
College				
Bus. or Trade School				
Professional School				

HAVE YOU EVER BEEN CONVICTED OF A CRIME? X No ___ Yes

If yes, explain number of conviction(s), nature of offense(s), dates of conviction(s), sentence(s) imposed, and type(s) of rehabilitation. _____

_____

APPLICATION FOR EMPLOYMENT

DO YOU HAVE A DRIVER'S LICENSE? ___ Yes X No

What is your means of transportation to work? BUS

Driver's license number _____ State of issue _____

Operator ___ Commercial (CDL) ___ Chauffeur ___

Expiration date _____

Have you had any accidents during the past three years? ___ Yes ___ No

If so, how many? _____

Have you had any moving violations during the past three years? ___ Yes ___ No

If so, how many? _____

Please list two references other than relatives or previous employers.

Name DOR Weeder	Name _____
Position Case Worker	Position _____
Company _____	Company _____
Address _____	Address _____
_____	_____
Telephone (720) 887-2211	Telephone (___) _____

APPLICATION FOR EMPLOYMENT

MILITARY

HAVE YOU EVER BEEN IN THE ARMED FORCES? __ Yes X No

ARE YOU NOW A MEMBER OF THE RESERVE OR NATIONAL GUARD? __ Yes X No

Branch _____ Specialty _____

Date Entered _____ Discharge Date _____

WORK EXPERIENCE

Please list your work experience for the **past five years** beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name Country Buffet
Position Greeter/Seater
Company _____
Address _____
Telephone (303) 428-6578

Supervisor name Ernie

Employment dates	Pay or salary
From March 2013	Start 8.50
To Present	Final

Your last job title _____

Reason for leaving (be specific) _____

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.

Name Better Business Bureau
Position Intern
Company _____
Address _____
Telephone (____) _____

Supervisor name Kevin

Employment dates	Pay or salary
From Feb 2012	Start 0.00
To May 2012	Final 0.00

Your last job title Intern

Reason for leaving (be specific) Internship ended

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.

APPLICATION FOR EMPLOYMENT

WORK EXPERIENCE

Please list your work experience for the **past five years** beginning with your most recent job held.
If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name _____ Position _____ Company _____ Address _____ _____ Telephone (____)_____	Supervisor name _____	
	Employment dates From To	Pay or salary Start Final
	Your last job title _____	
Reason for leaving (be specific) _____		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.		

Name _____ Position _____ Company _____ Address _____ _____ Telephone (____)_____	Supervisor name _____	
	Employment dates From To	Pay or salary Start Final
	Your last job title _____	
Reason for leaving (be specific) _____		
List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.		

May we contact your present employer? __ Yes X No

Did you complete this application yourself X Yes __ No

If not, who did? _____

Form W-4 (2011)

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 2011 expires February 16, 2012. 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 $950 and includes more than $300 of unearned income (for example, interest and dividends).

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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 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. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
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 $1,900 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. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children	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	

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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 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.

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **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.**

OMB No. 1545-0074

2011

1 Type or print your first name and middle initial.	Last name	2 Your social security number
Christina S	Ward	521-93-2139
Home address (number and street or rural route)	3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate.	
1027 E. 9th Ave #102	**Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	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. ▶ ☐	
Broomfield, CO 80020		

5	Total number of allowances you are claiming (from line H above **or** from the applicable worksheet on page 2)	5 0
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2011, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ [signature] **Date** ▶ 4/5/13

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)

CMG
CORPORATE MANAGEMENT GROUP
"your workforce management & staffing experts"

ANTI-HARASSMENT POLICY

It is Corporate Management Group's (CMG) policy that all employees should be able to enjoy a work environment free from all forms of discrimination, including harassment. As such, CMG is committed to vigorously enforcing their Anti-harassment Policy. This policy applies to all employees of the organization (without regard to position) and individuals not directly connected to CMG (e.g., an outside vendor, consultant, customer or guest). Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, creed, religion, national origin, sex, marital status, status with regard to public assistance, membership or activity in a local commission, disability, sexual orientation or veteran status. Harassment is considered a form of discrimination and is specifically included among the prohibitions under Title VII of the Civil Rights Act of 1964. In addition, retaliation or reprisal taken against anyone who has expressed concern about harassment or discrimination against the individual raising the concern is illegal.

The Equal Employment Opportunity Commission (EEOC) defines sexual harassment as "unwelcome sexual advances, requests for sexual favors, sexual comments, or other verbal or physical acts of a sexual or sex-based nature including, but not limited to drawings, pictures, jokes, and/or teasing where (1) submission to such conduct is made either explicitly or implicitly a term or a condition of an individual's employment; (2) an employment decision is based on an individual's acceptance or rejection of such conduct; or (3) such conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment."

The Anti-harassment Policy prohibits harassment and/or retaliation by any individual employed by, doing business with or for, or visiting CMG. Employees who believe they have been the subject of harassment and/or retaliation or an employee who may have been witness to harassment and/or retaliation must report the incident immediately. Information and/or allegations must be reported to a manager of CMG **(by telephoning 866.920.1425 or 303.920.1425)**. Only those who have an immediate need to know, including the alleged target of harassment or retaliation, the alleged harassers or retaliators, and any witnesses may find out the identity of the complainant. All individuals contacted in the course of an investigation will be advised that all persons involved in a charge are entitled to respect and that any retaliation or reprisal against an individual who is an alleged target of harassment or retaliation, who has made a complaint, or who has provided information in connection with a complaint, is a separate violation of CMG's policy. All information will be disclosed only on a need-to-know basis to allow CMG to

investigate and resolve the incident. CMG recognizes the serious nature of harassment and therefore will endeavor to protect the employee who may have been subjected to harassment, any witnesses and the party against whom allegations have been filed to every possible extent.

Harassment is unlawful and has a negative impact on employees. Violation of the Anti-harassment Policy will not be tolerated by CMG and may result in discipline up to and including termination. Offensive acts or conduct have no legitimate business purpose; accordingly, any employee, regardless of his/her position within CMG, who it is determined has engaged in such conduct will be made to bear the full responsibility for such unlawful conduct.

With respect to sexual harassment, the following is prohibited:

1. Unwelcome sexual advances, request for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, especially where:

   - ☐ Submission to such conduct is made either explicitly or implicitly a term or condition of employment;
   - ☐ Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or
   - ☐ Such conduct has the purpose or effect of creating an intimidating, hostile or offensive working environment.

2. Offensive comments, jokes, innuendoes and other sexually-oriented statements.

If Harassment Occurs:

1. When possible, confront the harasser and tell him/her to stop. Sometimes a simple confrontation will end the situation.
2. If confrontation is unsuccessful, immediately contact your CMG supervisor to report the harassment.
3. An investigation will be conducted and appropriate action taken, including disciplinary measures. We will investigate, in confidence; all reported incidents of harassment and retaliation.

Employee Signature: _____

Date: 4/5/13

PLEASE READ CAREFULLY
APPLICATION FORM WAIVER

In exchange for the consideration of my job application by Corporate Management Group, Inc.,

I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements and the like as they may exist from time to time, or other company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of Corporate Management Group, Inc. (CMG), or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by an officer of CMG. Both the undersigned and CMG may end the employment relationship at any time, without specified notice or reason. If employed, I understand that CMG may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination. I hereby give CMG permission to contact schools, all previous employers (unless otherwise indicated), references and others and hereby release CMG from any liability as a result of such contact.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by CMG. 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 CMG policies.

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

I understand that, in connection with the routine processing of your employment application, CMG may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics and mode of living. Upon written request from me, CMG will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with CMG shall be probationary for a period of ninety (90) days and further that at any time during the probationary period or thereafter, my employment relationship with CMG is terminable at will for any reason by either party.

Signature of applicant _____ Date: 4/5/13

IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION

Name: Christina Ward

Address: 1027 E. 9th Ave #102 Broomfield, CO 8002

Home Phone: 720-474-2584

Person(s) to contact in case of an emergency on the job (in order of preference):

1. **Name:** Connie Milles (mother)

   Phone (work):

   Phone (home): 720-732-8070

2. **Name:** Muriel Milles (Grandmother)

   Phone (work):

   Phone (home): 303-439-9140

Additional information you want CMG and our clients to know in the event of an emergency:

I am Extremely Allergic to Penicillian

Affirmation of Legal Work Status
Pursuant to § 8-2-122, Colorado Revised Statutes

Employee Name: Ward (Last) Christina (First) Jaime (Middle) 03/31/94 (Date of Birth)

Social Security Number: 521-93-2139 Date of Hire: 4/5/13

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

I affirm all four of the following:

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

Print Name of Employer (or Designated Representative) | Official Title

Signature of Employer (or Designated Representative) | Date Signed

Corporate Management Group 12000 N. Washington Street #290
Thornton, CO 80241 | 303-920-1425

Business or Organization Name | Employer Phone Number

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

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

This affirmation is provided as a courtesy by the Colorado Division of Labor.

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*)	First Name (*Given Name*)	Middle Initial	Other Names Used (*if any*)
Ward	Christina	J	Tina

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code
1027 E. 9th Ave	102	Broomfield	CO	80020

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
03/31/94	521-93-2139	Cjward94@yahoo.com	720-474-2584

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

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

☒ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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

3-D Barcode
Do Not Write In This Space

Signature of Employee:	Date (*mm/dd/yyyy*): 4/5/13

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

STOP **Employer Completes Next Page** STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: Id Card		Document Title: SS Card
Issuing Authority:		Issuing Authority: CO		Issuing Authority: dept of Health
Document Number:		Document Number: 11-355-0373		Document Number: 521-93-2139
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: 3-30-15		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)*: 4-5-13 ***(See instructions for exemptions.)***

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
[signature]	4-12-13	Account Mgr.

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Kool	Tina	CMG

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
12000 N. Washington St.	Thornton	CO	80241

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

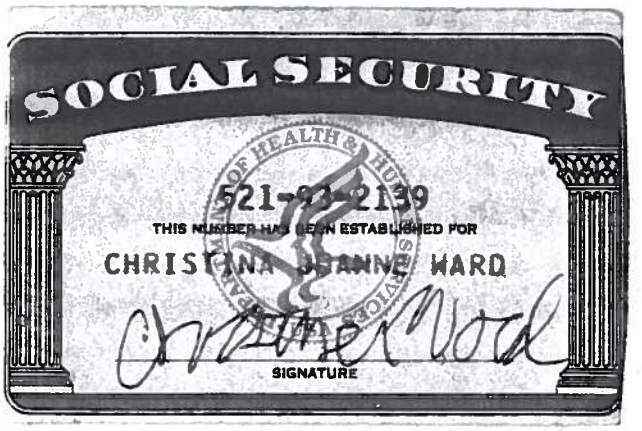
A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

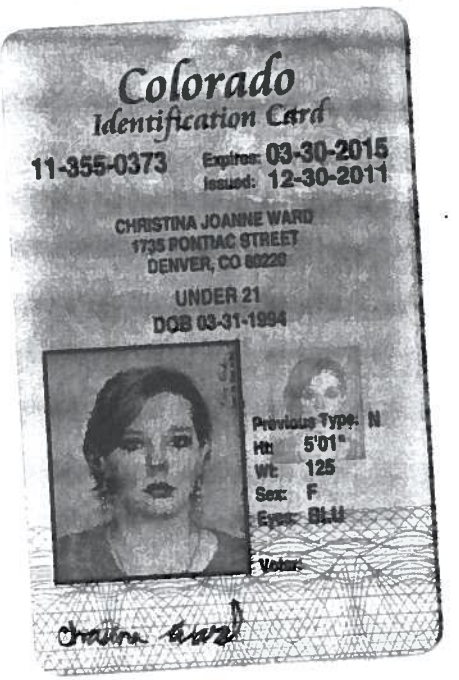
C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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:


SOCIAL SECURITY
521-93-2139
THIS NUMBER HAS BEEN ESTABLISHED FOR
CHRISTINA JOANNE WARD
SIGNATURE


Colorado
Identification Card
11-355-0373
Expires: 03-30-2015
Issued: 12-30-2011
CHRISTINA JOANNE WARD
1735 PONTIAC STREET
DENVER, CO 80220
UNDER 21
DOB 03-31-1994
Previous Type: N
Ht: 5'01"
Wt: 125
Sex: F
Eyes: BLU
Veter:

Authorization of Direct Deposit

The undersigned (hereafter referred to as the "employee") hereby authorizes and requests PAYCOM to make deposits from time to time in the account(s) identified below and authorizes the bank to accept such deposits. It is agreed that these deposits may be made electronically and under the Rules of the National Automated Clearing House Association. It is agreed that PAYCOM is only responsible for direct deposit of funds that have previously been received from _____ hereafter referred to as the "employer".

Attach a voided check, copy of a check, or spec sheet for each account. Indicate whether it is a checking or saving account. (No deposit slips)

1. Call your bank and confirm the **ACH Routing Number(s)** and Account numbers for **Checking and/or Savings**
2. Complete and Sign the form

Main Account (Net Pay) - Checking or Savings Account (circle one)

Acct # 121206531O

ACH Routing # 1/1/0/1/2/0/0/0/0/7/6/

Bank Name Wells Fargo 50%

Additional Account - Checking or Savings Account (circle one)

Acct # _____ Dollar Amount 50%

ACH Routing # /_/_/_/_/_/_/_/_/_/

Bank Name _____

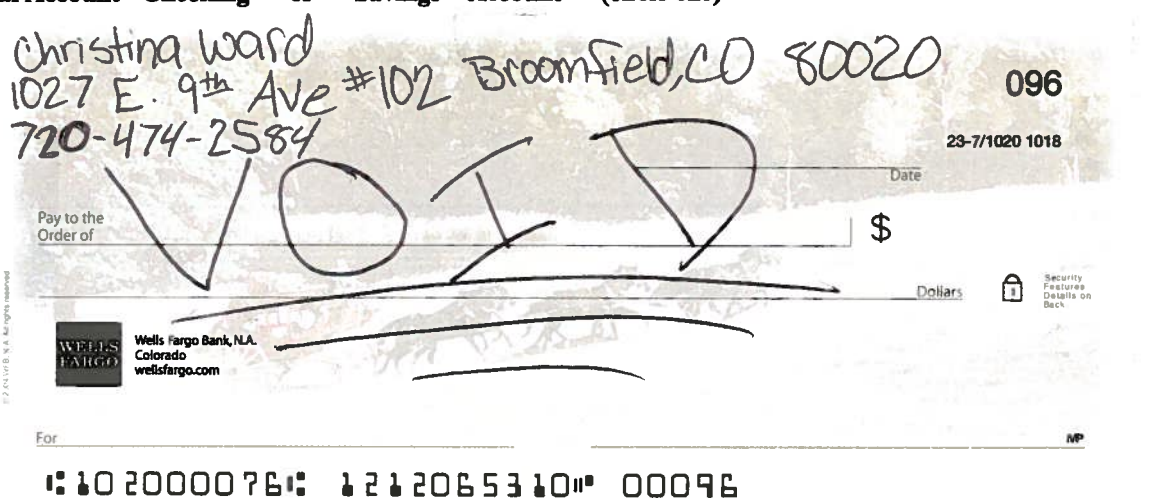
Additional Account - Checking or Savings Account (circle one)

Acct # Christina Ward
1027 E. 9th Ave #102 Broomfield, CO 80020
720-474-2584

ACH R

Bank N

Additio



Acct # _____ Dollar Amount _____

ACH Routing # /_/_/_/_/_/_/_/_/_/

Bank Name _____

Employee Name_____ **SS#**_____/_____/_____

Address_____**City**_____**State**___**Zip**_____

Employee Signature _____

Form **8850** (Rev. August 2009)
Department of the Treasury
Internal Revenue Service

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

▶ See separate instructions.

OMB No. 1545-1500

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

Your name Christina J. Ward Social security number ▶ 521-93-2139

Street address where you live 1027 E. 9th Ave #102

City or town, state, and ZIP code Broomfield, CO 80020

County Broomfield Telephone number (720) 474-2584

If you are under age 40, enter your date of birth (month, day, year) 03/31/94

1 ☐ Check here if you are completing this form **before** August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.

2 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

3 ☒ 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 discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and,** for at least 4 weeks during the past year, I received unemployment compensation.
- I am at least age 16 but **not** age 25 or older, **and:**
  - **a** During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
  - **b** During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
  - **c** I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate **or** I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability **and,** during the past year, you were:

- Discharged or released from active duty in the U.S. Armed Forces, **or**
- Unemployed for a period or periods totaling at least 6 months.

5 ☐ 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 ▶ [signature] **Date** 4/5/13

Form A (revised 07/09) **WORK OPPORTUNITY TAX CREDIT**

PLEASE CHECK "YES" OR "NO" AND ANSWER ALL QUESTIONS

Name Christina Ward
Address 1027 E. 9th Ave #102
City Broomfield State CO Zip 80020 Social Security # 521-93-2139
Date of Birth 03/31/94 Age 19

Please CHECK ONE ANSWER for each of the following questions, and complete question #5:

1. Have you or any family member living with you received Temporary Assistance to Needy Families (TANF) or Aid to Families with Dependent Children (AFDC) during the past 24 months? **Yes** ☐ **No** ☒

2. Have you or any family member living with you received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) at any time during the past fifteen (15) months? **Yes** ☒ **No** ☐

3. Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days? **Yes** ☐ **No** ☒

4. Are you part of the Ticket to Work program? **Yes** ☐ **No** ☒

5. **Name of person who received benefits** Christina Ward
Relationship Self **City & State where benefits received** Broomfield, CO

6. Are you a veteran? **Yes** ☐ **No** ☒ and Disabled due to service? **Yes** ☐ **No** ☒
Service Dates: From: _____ To: _____ Branch: _____

7. Have you been unemployed at any time during the last 12 months? **Yes** ☒ **No** ☐
If yes, dates of unemployment: From: ~~Jan~~ Nove 2011 To: July 2012
Did you receive unemployment compensation at any point during your unemployment?
If yes, dates received compensation: From: _____ To: _____ **Yes** ☐ **No** ☒

8. Have you been convicted of a felony or released from prison in the last 12 months?
Date of Conviction: _____ Date of Release: _____ **Yes** ☐ **No** ☒
Parole Officer's Name: _____ Parole Officer's Phone # _____

9. Have you received rehabilitation services from a State approved or Department of Veterans Affairs approved *Vocational* rehabilitation agency? **Yes** ☐ **No** ☒
Name of Agency _____ Phone # _____
Address of Agency _____ Counselor's Name _____

10. Have you attended High School, College or Technical School for more than an average of 10 hours per week at any time during the last 6 months? **Yes** ☐ **No** ☒

11. Did you receive a high school diploma or GED? If yes, date received: May 2012 **Yes** ☒ **No** ☐
Have you been employed or been admitted to technical school or college since then? **Yes** ☐ **No** ☒

12. How much in gross wages have you earned TOTAL in the past six months? $ _____

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, or the Department of Labor.

→ NEW HIRE SIGNATURE _____ DATE 4/5/13

Questions below to be completed by manager
Starting Wage _____ Position _____
Has employee worked for this company before? _____ If yes, date and location _____

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: November 30, 2011

YOUTH SELF-ATTESTATION FORM
Work Opportunity Tax Credit Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with Form ETA 9061 for each certification request filed.

New Hire Name: Christina J. Ward

Social Security Number: 521-93-2139 Date of Birth: 3/31/94

Employer Name: Employer Solutions Staffing Group

Employer Federal ID (EIN) Number: -

Please check all the statements that apply to you. Sign and date this form where indicated below.

☒ In the past 6 months, I have not attended a secondary, technical or postsecondary school for more than an average of 10 hours per week, not counting periods during which the school is closed for scheduled vacations.

☐ I do not have a High School Diploma or GED certificate.

☒ I have a High-School diploma or GED certificate awarded more than 6 months ago and I have not attended or been admitted to a technical or post-secondary school. I also have not held a job (other than occasionally) since receiving my High-School diploma or GED certificate.

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

New Hire's Signature: _____ Date 4/5/13

Privacy Act Notice:
The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form, including the Social Security Number, will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OM B control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of Adult Services, Room S-4209, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

Essential StaffCARE®

Health Insurance Enrollment Form

Complete the Enrollment Form to Elect or Decline Coverage

- You **MUST** Complete the Enrollment Form for the New Hire Process
- You **MUST** Elect or Decline Coverage on the Enrollment Form
- Return the Enrollment Form to your Branch Manager
- Keep the Benefit Page for Your Records and Plan Information

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.

CMG
CORPORATE MANAGEMENT GROUP

CMG

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

The Essential StaffCare Medical/Rx, Accidental Loss of Life, Limb & Sight, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.204, 26.212, and 26.213. The Term Life and Short-Term Disability Plans are underwritten by BCS Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

Frequently Asked Questions

When does coverage go into effect?

Coverage will begin the Monday following a payroll deduction and continues as long as you have a deduction from your paycheck. Please review your pay check stub for deductions. If you miss a paycheck, to avoid a break in coverage, you may make direct payments to PAI. After six consecutive weeks without a payroll deduction or direct premium payment, coverage will be terminated and COBRA information will be sent at that time. After six months if there has not been a deduction from your paycheck, please fill out a new enrollment form. Missing information will delay the process.

When can I make changes?

Coverage may be canceled or reduced at any time, unless your employer takes premium deductions pre-tax. To make changes or cancel coverage by telephone call (800) 269-7783 within 30 days of the date of your first paycheck. You will be prompted to enter your PIN CODE plus the last four digits of your Social Security number (SSN).

PIN CODE: 142 +____ (last four digits of your SSN)

Remember, it may take up to two or three weeks for the changes or cancellation to be reflected on your paycheck. Coverage will continue as long as you have a paycheck deduction. If you do not enroll within 30 days of your first paycheck or open enrollment date, you and your dependents will have to wait until the next open enrollment or until you have a qualifying life event. A qualifying life event is defined as a change in your status due to one of the following:

Marriage or divorce, Birth or adoption of a child(ren); Termination; Loss of insurance coverage by your spouse; Death of an immediate family member; Medicare entitlement; Employer bankruptcy; Loss of dependent status or Loss of prior coverage. In addition, you may request a special enrollment (for yourself, your spouse and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit.

Who is eligible to enroll?

Dependents are eligible to enroll for all products, except for the short-term disability plan. Eligible dependents include an employee's spouse and unmarried/married children (natural, adopted or step-children up to age 26).

Networks

Medical

Beechstreet 1-866-907-3619
www.beechstreet.com
(available except where other networks are used)

PHCS Network 1-866-671-7427
www.phcs.com
(available for residents of Arkansas and Utah)

Multiplan Network 1-888-342-7427
www.multiplan.com
(available for residents of West Virginia)

Prescription

Caremark 1-888-963-7290
www.caremark.com

Dental

DenteMax 1-800-752-1547
www.dentemax.com

Vision

EyeMed Vision Care 1-866-723-0513
www.eyemedvisioncare.com

Important Information

This is a limited benefit medical insurance plan. This is not major medical insurance. Please read this benefit packet in its entirety. This plan is only available as an employer-sponsored benefit. It cannot be purchased as an individual policy. All members may receive additional deductions and additional weeks of coverage from their date of cancellation. If you are age 65 or older or if you or your dependents are eligible for Medicare and you are enrolled in the Essential StaffCARE employee benefits program, you need to obtain an important notice regarding Medicare-part D Prescription Drug Coverage. For the Medicare-part D notice, contact your Human Resource Department.

Essential StaffCARE Customer Service: 1-866-798-0803

BENEFITS AT A GLANCE

Group Number: 221900-CMG

Medical Benefits - Plan 2 — Weekly Rates

Inpatient Benefits	
Annual Inpatient Maximum	No Maximum
Daily Standard Care Maximum	$500 per day‡
Daily Intensive Care Unit Maximum	$600 per day‡
Surgery (no limit on # of procedures)	$3,000 per inpatient surgical procedure
Anesthesiology	$600 per inpatient surgical procedure
Skilled Nursing (payable for stays in a skill nursing facility after a hospital stay)	$100 per day‡

Accidental Loss of Life, Limb & Sight	
Employee Amount	$20,000
Spouse Amount	$20,000
Child Amount (6 months to 24 years old)	$5,000
Infant Amount (15 days to 6 months)	$2,500

Outpatient Benefits	
Annual Outpatient Maximum	$1,500
Physician Office Visit†	$100 per visit
Diagnostic Lab†	$75 per testing day
Diagnostic X-ray†	$200 per testing day
Ambulance Services†	$300 per trip no limit on # of trips
Physical, Occupational, and Speech Therapy†	$50 per visit
Emergency Room† - Sickness / Accident	$200 / $500 per visit
Outpatient Surgery†	$500 per procedure
Anesthesiology†	$200 per procedure

Drug Card Benefits	
Prescription Drug Benefits° (per script)	$10 Generic / $30 Brand

Wellness Benefit	
Wellness Benefit (once per year)	$75 lump sum payment

Employee Only $23.69 | **Employee + One $48.08** | **Employee + Family $64.20**

Dental Benefits — Weekly Rates

Annual Maximum Benefit $750 | **Deductible $50**

	Waiting Period	Co-insurance	
Coverage A	None	80%	Exams, Cleanings, Intraoral Films and Bitewings
Coverage B	3 months	60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures
Coverage C	12 months	50%	Periodontics, Crowns, Bridges, Endodontics and Dentures

Employee Only $5.23 | **Employee + One $10.46** | **Employee + Family $17.26**

Vision Benefits — Weekly Rates

	In-Network	Out-of-Network
Eye Examination for Glasses (including dilation)	Co-pay: $10, plan pays 100%	Plan pays $35, you pay remaining balance
Frames**	Plan pays $110 allowance§	Plan pays $55
Standard Plastic Lenses for Glasses*	Co-pay: $25, plan pays 100%	Co-pay: $0, plan pays $25-$55***
Standard Contact Lens Fit*	Plan pays up to $55	You pay 100% of the price
Premium Contact Lens Fit*	Plan pays 10% off the price	You pay 100% of the price
Contact Lenses or Disposable Lenses*	Plan pays $110 allowance§	Plan pays $88
Contact Lenses Medically Necessary*	Plan pays 100%	Plan pays $200

Employee Only $2.35 | **Employee + One $4.00** | **Employee + Family $5.64**

Short-Term Disability — Weekly Rates

Benefit: 60% of Salary up to $150 per week | Waiting Period / Maximum Benefit Period: 7 days / 26 weeks

Employee Only $4.20

Term Life Benefits — Weekly Rates

Employee Amount	$10,000 Reduces to $7,500 at 65, $5,000 at age 70	Child Amount (6 months to 24 years old)	$5,000
Spouse Amount	$5,000 Terminates at age 70	Infant Amount (15 days to 6 months)	$1,000

Employee Only $0.60 | **Employee + One $0.90** | **Employee + Family $1.80**

† up to annual outpatient maximum ‡ No limit on # of days ° $50 Monthly Maximum (no carry over)
* Once every 12 months. ** Once every 24 months. *** Single Vision: $25, Bifocal: $40, Trifocal: $55
§ Discount on balance above allowed amount; Frames: 20%, Conventional Contact Lenses: 15%.

EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

MEDICAL AND ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT BENEFIT

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane;
- Declared or undeclared war;
- Serving on full-time active duty in the armed forces;
- The covered person's commission of a felony;
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law;
- With regard to the accidental loss of life, limb or sight benefit - sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

No benefits will be paid for:

- Eye examinations for glasses; any kind of eye glasses, or vision prescriptions;
- Hearing examinations or hearing aids;
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident;
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force;
- Services provided by a member of the covered person's immediate family.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on Covered Procedures or limitations, please contact Essential StaffCARE Customer Service at 1-866-798-0803.

VISION

No benefits will be paid for any materials, procedures or services provided under Workers' Compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

PRESCRIPTION DRUGS

No benefits will be paid for over the counter products or medications or for drugs and medications dispensed while you are in a hospital.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury;
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent; or a person who resides in your home;
- Declared or undeclared war or act of war;
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony;
- Your participation in a riot;
- If you engage in an illegal occupation;
- Release of nuclear energy;
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft;
- Work-related injury or sickness.

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

TERM LIFE

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

ND 221900-CMG | OFFICE USE ONLY | ReHire Date __/__/____

EMPLOYEE INFORMATION (Must Be Filled Out)

ENROLLMENT FORM - PLAN 2

USE BLACK or BLUE INK ONLY

Social Security Number 521-93-2139

Date of Birth 03/31/1994 Sex M [X] F

Name Christina Ward

Street Address 1027 E. 9th Ave #102

City Broomfield State CO Zip 80020

Home Phone 720-474-2584

Do you or any dependents have Medicare?

☐ Yes ☐ No If Yes:

Medicare Health Insurance Claim Number (HICN) ____________

Medicare Effective Date __/__/____

Names of Covered Person(s)

1. ____________
2. ____________
3. ____________
4. ____________

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

Signature [signature] Date 4/5/13

- You MUST enroll in the Medical Insurance Plan before adding any additional benefits.
- Your coverage level for the additional benefits will be identical to your medical plan selection.

BENEFIT SELECTION

Weekly Rates

MEDICAL

☐ **$23.69 Employee Only**
☐ **$48.08 Employee +1**
☐ **$64.20 Employee + Family**
☒ **NO to all benefits.** *If checked, stop! Go no further.*

DENTAL

☐ YES ☒ NO

$5.23 Employee Only
$10.46 Employee +1
$17.26 Employee + Family

VISION

☐ YES ☒ NO

$2.35 Employee Only
$4.00 Employee +1
$5.64 Employee + Family

TERM LIFE

☐ YES ☒ NO

$0.60 Employee Only
$0.90 Employee +1
$1.80 Employee + Family

SHORT-TERM DISABILITY

☐ YES **$4.20 Employee Only**
☒ NO

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

REQUIRED DEPENDENT INFORMATION

Name ____________
Social Security Number ___-__-____
Date of Birth __/__/____ Sex M F
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

Name ____________
Social Security Number ___-__-____
Date of Birth __/__/____ Sex M F
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

Name ____________
Social Security Number ___-__-____
Date of Birth __/__/____ Sex M F
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

Name ____________
Social Security Number ___-__-____
Date of Birth __/__/____ Sex M F
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

BENEFICIARY INFORMATION

For Term Life \ Accidental Loss of Life, Limb & Sight, please write in your beneficiary information.

NAME OF BENEFICIARY ____________

RELATIONSHIP ____________

Accidental Loss of Life, Limb & Sight is part of the Medical Benefit.

Form: ESC S P2D v9.1

To: All Employees
Quien: *Todos Empleados*

From: Corporate Management Group & Employer Solutions Group
De: *Corporate Management Group y Employer Solutions Group*

Re: Stop Payment Check Fee
Re: *Tarifa de cheque parado*

Effective immediately, to replace a lost or stolen check, $50.00 will be deducted from the replacement check for a stop payment fee and for a reprocessing fee. *Efectivo inmediatamente, para reemplazar un cheque de sueldo perdido o robado, $50.00 de tarifa sera deducido de el cheque reemplazado para parar el cheque original y para procesarlo denuevo.*

If you lose your check, we will first have to verify that it has not been processed through the bank. If it has not, a new check will be issued, minus the $50.00 fee. *Si usted pierde su cheque, tendremos que verificar que no ha sido procesado en el banco. Si no, un cheque nuevo sera processado, menos las tarifa de $50.00.*

If your check is stolen, we will first need a copy of the police report before a new check can be reissued. After we receive a copy of the police report, a new check will be issued following the same procedures as listed above. *Si su cheque es robado, necesitaremos una copia de el reporte de policia antes de que un cheque nuevo sera procesado. Despues de obtener una copia del reporte de policia, un cheque nuevo sera procesado usando los mismos procedimientos mencionados arriba.*

If you have any questions regarding this new policy, please contact your On-Site Representative or the Corporate Office (303-920-1425). *Si usted tiene preguntas sobre esta poliza, por favor contacte a su representante de CMG o la oficina corporal al (303-920-1425)*

Thank you for your continued dedication and hard work!

Gracias por su dedicacion continua!

By signing below you are confirming that you understand the above policy.
Con su firma abajo usted esta confirmando que entiende la poliza descrita.

Signature/*Firma*: _____
Date/*Fecha*: 4/25/13

CMG
CORPORATE MANAGEMENT GROUP

Notification of Colorado Law Requirement
Unemployment Acknowledgement

According to Colorado Statutes section 8-73-105.3. A temporary employee who is given a notice that the employee is required to contact or notify the employer upon completion of an assignment and to be available to work, as agreed upon at the time of hire, during a specified period of time, on specified dates, or upon call by the employer on an as-needed basis and who does not contact or notify the employer upon completion of an assignment in compliance with the notice and is not available to work at the agreed-upon times is deemed to have voluntarily terminated employment for the purpose of determining benefits pursuant to section 8-73-108 (5) (e). Also, a temporary employee who agrees to work on an as-needed basis and refuses all work within three separate pay periods when contacted by the employer is deemed to have voluntarily terminated employment for reasons that may or may not allow an award of benefits pursuant to section 8-73-108.

It is you responsibility to contact or notify CMG once your assignment ends. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact or notify CMG once an assignment ends. I also acknowledge that I have received a separate copy of this form.

CSW (Initial)

Employee Signature:

4/5/13
Date:

Christina Ward
Employee (please print your name here)

BackTrack
EMPLOYMENT SCREENING SPECIALISTS

8850 Tyler Blvd., Mentor, OH 44060 Phone (440) 205-8280 Fax (440) 205-8355
Visit our website at: www.backtracker.com or email us at: btsearches@backtracker.com

BACKGROUND INFORMATION FORM FOR BACKGROUND CHECK

BackTrack, Inc. is an employment screening company that conducts background checks on prospective employees/employees for our clients as part of their standard hiring procedure. In order to perform this check, we need you to provide the following information. Please be sure to fill out this form completely and legibly.

APPLICANT INFORMATION (please print clearly & accurately)

Position Applying For: Lead Generator — Expected Salary:

Last Name Ward — First Name Christina — Middle Name JoAnn E

Maiden Name — Any Other Name(s) Used Tina — Phone ( )

Home Address 1027 E. 9th Ave #102 — E-Mail Address

City Broomfield — State CO — Zip 80020 — County — From Mth/Yr — To Mth/Yr

Social Security Number * 521-93-2139 — Date of Birth * 03/31/94 — Military Branch of Service

*For background screening purposes only

Driver's License Number — State License was Issued

High School — City/State Location — Year Graduated — Full Name Diploma Issued Under

If GED received, in what State — City/State Location — Date Received — Name Used for GED

College — City/State Location — Year Graduated

Degree Rec'd:
☐ Associate ☐ Bachelor ☐ Master ☐ Other _____ Student ID Number: — Full Name Used

List Previous Addresses (to cover last 7 years)
Address — City/State — Zip

County — From Mth/Yr — To Mth/Yr

Address — City/State — Zip

County — From Mth/Yr — To Mth/Yr

Are you currently employed? ☐ **YES** ☐ **NO**

May we contact your CURRENT EMPLOYER now? ☐ **YES** ☐ **NO** **(If marked YES, we WILL contact.)** _____ **Please Initial**

IMPORTANT: If you are currently employed and do NOT wish for your current employer to be contacted, please check NO on the above box.

NOTE: The absence of any of the above information could result in a delay in processing your background. If necessary, a representative from BackTrack, Inc. will contact you for additional information in order to expedite the background process. Thank you for your assistance.

---FOR CLIENT USE ONLY – DO NOT WRITE BELOW THIS LINE---

CLIENT INFORMATION	SERVICES REQUESTED ☐ RUSH ORDER ($27 extra charge)
Name:	PACKAGE: ☐ Level I (employment, education, criminal search, credit or SSN search, driving) ☐ Level II (employment, criminal search, credit or SSN search, driving) ☐ Level III (employment, education, criminal search) ☐ Level IV (employment, criminal search, credit or SSN search) ☐ Level V (criminal and SSN search) ☐ Level VI (employment, education, criminal search, credit or SSN search) (Above packages check here for 5 year emp. history____ check here for only 3 year___)
Title:	
E-Mail Address:	
Company Name:	
Address: City/State/Zip:	☐ Criminal History (county) ☐ Federal District Search ☐ Civil Litigation ☐ Statewide Search (where available) ☐ CrimeTrack (Criminal Database and National Sex Offender Search) ☐ GlobalTrack (Patriot Act Search)
If Applicable, Division or Code #:	☐ Credit Report
Phone Number:	☐ Employment History ☐ Education ☐ Driving Record ☐ SSN Search
Fax Number:	☐ Workers' Comp. ☐ Military ☐ Credential ☐ Bus/Personal Ref.

F10-1020

YOU MUST COMPLETE BOTH THE BACKGROUND INFORMATION FORM AND THE DISCLOSURE AND AUTHORIZATION FOR BACKGROUND CHECK

BackTrack
EMPLOYMENT SCREENING SPECIALISTS

8850 Tyler Blvd., Mentor, OH 44060 Phone (440) 205-8280 Fax (440) 205-8355
Visit our website at: www.backtracker.com or email us at: btsearches@backtracker.com

DISCLOSURE AND AUTHORIZATION FOR BACKGROUND CHECK

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Employer ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character and general reputation which can involve interviews with sources such as your friends and/or associates. These reports may contain information regarding your credit history, criminal history from various state and private sources along with other public records available, social search, motor vehicle records ("driving records"), verification of your education or employment history, or workers' compensation claims. 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. Workers compensation will only be requested in compliance with the ADA and/or any other applicable state laws. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer 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 BackTrack, Inc., 8850 Tyler Boulevard, Mentor, OH 44060, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, 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. According to the Fair Credit Reporting Act, you are entitled to know if employment is denied or you otherwise suffer an adverse employment action because of information obtained from your prospective employer/employer from a consumer reporting agency. If so, you will be advised and be given the name of the agency or source of information.

Maine and New York applicants/employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly. You may also contact the Company to request the name, address, and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which the Company shall provide within 5 days.
New York applicants/employees only: I acknowledge receipt of a copy of Article 23-A of New York Correction Law. ☐
Oregon applicants/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 the Company has not maintained secured records is available to you upon request.
Washington State applications/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 NOTICE 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 those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. 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, Employer, or insurance company to furnish any and all background information requested by BackTrack, Inc., another outside organization acting on behalf of Employer, and/or Employer itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants/employees only: ☐ Please check this box if you would like to receive a copy of your consumer report.

California applicants/employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law. ☐

F11-0920

Signature X [signature] **Date** 4/5/13

Printed Name Christina Ward **Company Applying To** CMG

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security **Report Prepared: 04/08/2013**

E-Verify **Page: 1 of 1**

Case Verification Number: 2013098135116RX

Case Information:

Employee Information:

Last Name:	Ward	First Name:	Christina
Middle Initial:	J	Maiden Name:	
Social Security Number:	*** ** 2139	Date of Birth:	03/31/1994
Citizenship Status:	A citizen of the United States		

Document Information:

List B Document:	ID card issued by a U.S. federal, state or local government agency	List C Document:	Social Security Card
Alien Number:		I-94 Number:	

Additional Information:

Hire Date:	04/05/2013	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CKRO8757	Submitted On:	04/08/2013

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:	Maiden Name:
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: CKRO8757 Closed On: 04/08/2013

SENSITIVE BUT UNCLASSIFIED

BackTrack

Employment Screening Specialists

8850 Tyler Blvd., Mentor, OH 44060 (440) 205-8280 Fax (440) 205-8355 www.backtracker.com

To:	Ms. Angie Gonzales	**Name:**	**CHRISTINA JOANNE WARD**
Client:	**Corporate Management Group**	S. S. NO:	xxx-xx-2139
		Control Id:	892835
Location:	**Thornton, CO**	Client's Ref.No.	
Fax:		Client EMail:	Angie@corpmgmtgroup.com
Client ID:	4096-6595	Email cc to:	lincoln@corpmgmtgroup.com

Returned Report Log:

Date Sent	Report Status	Report Status Notes
4/8/2013	In Progress	
4/8/2013	Closed	

Database Search — Status: Closed

Search Type:	CrimeTrack Criminal and Sex Offender Database Search
Search Name:	**CHRISTINA JOANNE WARD**
Search Result:	Completed.
Search Date:	4/8/2013 2:44:10 PM
Country:	U.S.A.
Note:	**This database is a multi-jurisdictional search compiled from multiple sources consisting of court records, incarceration records, prison/inmate records, probation/parole/release information and all 50 States Sex Offender Database Registries. Also included are a multitude of databases covering U.S and foreign sanctions and watch lists provided by U.S and foreign governments and international organizations. These include but are not limited to OIG - U. S Department of Health and Human Services, Office of the Inspector General - Exclusions List, System for Awards Management (SAM), The Excluded Parties List System (EPLS), General Services Administration (GSA), OFAC Specially Designated Nationals (SDN) and Blocked Persons, OFAC Sanctioned Countries including Major Cities and Ports, Non-Cooperative Countries and Territories, Department of State Trade Control (DTC) Debarred Parties, U.S. Bureau of Industry & Security, Unverified Entities List, Denied Entities List, Denied Persons List, FBI Most Wanted Terrorists and Seeking Information, FBI Top Ten Most Wanted, INTERPOL Most Wanted List, Bank of England Sanctions List, OSFI - Canadian Sanctions List, United Nations Consolidated Sanctions List, Politically Exposed Persons List, European Union Terrorism List, and World Bank Ineligible Firms.**