

New Hire Application

Personal Data— PLEASE PRINT LEGIBLY IN INK

Last Name Gutierrez First Name Yudith Middle Initial _____
 Street Address 814 8th Ave Apt. _____
 City/State/Zip Worthington MN 56187
 Home Phone (605) 951-1689 Cell / Message Phone (605) 951-1589
 Company/Employer EDF Renewable Energy

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, current or indicated in this application, regarding my previous duties, responsibilities, performance, compensation and employment history.

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.

Yudith Gutierrez Yudith Gutierrez 6-10-13
 Name (Print or type) Applicant's Signature Date

A copy or facsimile will be considered the same as an original signature.

For ESSG Office Use Only

DOH _____	NHW _____	I-9 _____	8350 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (if applicable) _____	ESC Application _____

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

Employee Name: Yudith Gutierrez
Address: 814 8th Ave Northington MN 56187
Home Phone: (605) 951-1589

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

1. Name: Josh Carlson
Phone (work): (507) 277-1988
Phone (home): (507) 277-1988
2. Name: Debora Gutierrez
Phone (work): (605) 553-0647
Phone (home): (605) 553-0647

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



employer solutions staffing group.

STATEMENT OF CONFIDENTIALITY

This agreement made this 10 day of June, 2013, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Yudith Gutierrez 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

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 substantiated in the district and nonprohibitive of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been requested and compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439 Tel: 800-886-4777 or 952-941-9040 Fax: 800-886-0774 or 952-941-9041 ORANGE TREE EMPLOYMENT SCREENING's website is at www.orangetreescreening.com, or another outside organization. The scope of this notice and authorization is all encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.
New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.
Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel: 800-886-4777 or 952-941-9040. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING's website is at www.orangetreescreening.com, another outside organization acting on behalf of the company, and/or the company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by ESSG. <input type="checkbox"/> (Must include email address: _____)
California applicants or 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 at no charge if one is obtained by ESSG whenever you have a right to receive such a copy under California law. www.validityscreening.com/Site/PrivacyPolicy <input type="checkbox"/> (Must include email address: _____)

Signature: Judith Gutierrez Date: 06-10-13

BACKGROUND INFORMATION

Last Name: Gutierrez First: Judith Middle: _____

Other Names/Alias: _____

Social Security #*: 614-34-4777 Date of Birth (mm/dd/yyyy)*: 08-19-1986

Driver's License #: N284151784414 State of Driver's License: MN

Present Address: 814 8th Ave. Telephone # (Primary): (651) 951-1589

City/State/Zip: Worthington MN 56187

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



Direct Deposit/Payroll Debit Card Authorization

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card.
If you do not provide a written election, wages will be paid by Payroll Debit Card

SECTION 1 BASIC INFORMATION

Employee Name Yudith Gutierrez	SSN# (last 4 digits) 4777	Effective Date
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SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below)
 Payroll Debit Card (Please complete Sections 4 and 5 below)

SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: **Bank of the West**

Routing#: **121100782**

Account#: **459074824**

Account Type: Checking Savings Other:

I understand and acknowledge that if I do not provide a voided check (a deposit slip will not work) with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.

Initial **YG** Date **06-10-13**

- To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work)
- If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

SECTION 4 PAYROLL DEBIT CARD

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.

Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)

First Name	M.I.	Last Name	Date of Birth
Street Address (PO BOX NOT ACCEPTABLE)			Social Security#
City	State	Zip	Primary Phone

RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)

Payroll Debit Card Routing # 122242597	Payroll Debit Card Account #
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I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature: _____ Date: _____

SECTION 5 AUTHORIZATION

I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to include, if necessary, debit entries and adjustments to any credit entries made in error to my account(s). *E-mail is required for pay stub information.

*E-mail: **yudith.gz@gmail.com**

Employee's Signature: **Yudith Gutierrez** Date: **06-10-13**

ATTENTION: ESSG provides employees with electronic pay stubs. You are able to view your pay stub by using either of the following methods:

1. You can view your check stub by logging into the employee portal at www.MyPayESG.com

Your username is the first four letters of your last name followed by the last four numbers of your SSN.

For example: John Woods SSN: 111-22-3333 would have a username of Wood3333

Your password will initially be Temp1234, and you will be directed to change it when you first log in. Be sure to write down and keep your log in information in a secure location. For support please email MyPayESG@MyPayESG.com

2. You can also receive your check stub by email by providing us with your email address below.

Email address: judith.gz@gmail.com

ATENCIÓN: ESSG proporciona a los empleados con los talones de pago electrónicos. Usted puede examinar su talon de pago utilizando cualquiera de los métodos siguientes:

1. Usted puede ver su talón de cheque por la tala en el portal electrónico del empleado en www.MyPayESG.com

Su nombre de usuario son las cuatro primeras letras de su apellido seguido por los cuatro últimos dígitos de su número de seguro social.

Por ejemplo: Juan García SSN: 111-22-3333 tendría un nombre de usuario de Garc3333

Su contraseña inicialmente será Temp1234, y usted será dirigido a cambiarla la primera vez que inicie sesión. Asegúrese de anotar y guardar su información de registro en un lugar seguro.

2. También puede recibir su talón de cheque por correo electrónico. Por favor contacte a mvpavesg@mvpavesg.com por correo electrónico para informarle de su dirección de correo electrónico y todos sus talones de cheque serán enviados directamente a su correo electrónico.

Correo electrónico: _____



employer solutions staffing group.
Leveraging Resources in a Changing Market

INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

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

RESPONSIBILITIES OF THE INJURED WORKER:

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

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

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

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

Follow all physical restrictions at home and at work.

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

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

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

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

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

Signed: _____

Printed Name: _____

Yudith Gutierrez
Yudith Gutierrez

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

▶ See separate instructions.

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

Your name Yudith Gutierrez Social security number ▶ 614-34-4777
Street address where you live 814 8th Ave
City or town, state, and ZIP code Worthington MN 56187
County Nobles Telephone number (605) 951-1589
If you are under age 40, enter your date of birth (month, day, year) 08/19/1986

- 1 Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2 Check here if any of the following statements apply to you.
 - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 8 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 am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3 Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4 Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5 Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6 Check here if you are a member of a family that:
 - Received TANF payments for at least the past 18 months, or
 - Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, or
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

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

Job applicant's signature ▶ Yudith Gutierrez
For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Date 06-10-13

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

Employee Name: <u>Yudith Gutierrez</u>	Street Address: <u>814 8th Ave</u>	City/State: <u>Worthington MN 56187</u>	Zip: <u>56187</u>
SS#: <u>614-34-4711</u>	Date of Birth: <u>08/19/1986</u>	Age: <u>26</u>	Have you worked for this company before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

Yes No

1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? 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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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: <input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> 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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Are you a Veteran of the U.S. Military? *If yes, please provide a copy of your DD-214 and letter of separation. (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? <input type="checkbox"/> Have you been unemployed at any time during the last 12 months? <input type="checkbox"/> If yes, dates of unemployment - From: ____/____/____ To: ____/____/____ Did you receive unemployment compensation at any point during your unemployment? <input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months? Conviction Date: ____/____/____ Release Date: ____/____/____ Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
CA Residents: <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act? <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?		
SC Residents: <input type="checkbox"/> Do you receive Family Independence Benefits?		

PLEASE READ, SIGN, AND DATE:

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

New Employee Signature: Yudith Gutierrez Date: 08-19-12



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 for Form I-9 not later than the first day of employment, and not later than 90 days after the start of employment.)

Last Name (Family Name) Gutiérrez		First Name (Given Name) Yudith		Middle Initial	Other Names Used (if any)	
Address (Street Number and Name) 814 8th Ave.			Apt. Number	City or Town Worthington	State MN	Zip Code 56187
Date of Birth (mm/dd/yyyy) 08/19/1986	U.S. Social Security Number 614-39-4777	E-mail Address yudith.gz@gmail.com			Telephone Number (605) 951-1589	

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):

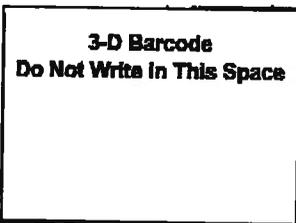
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field.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

Signature of Employee: Yudith Gutierrez	Date (mm/dd/yyyy): 06/10/2013
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Section 2 Preparer or Translator Information (Employers must complete and sign Section 2 for Form I-9 not later than the first day of employment, and not later than 90 days after the start of employment.)

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



Section 2: Employer's Authorized Representative's Declaration and Certification
 Employer's Authorized Representative's Declaration and Certification: Section 2 (including a business day's grace period) requires that employees first be authorized for employment. You must physically examine and document the individual's identity and employment authorization. This information must be documented in the appropriate document(s) and must be documented in the appropriate document(s).

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: <u>Passport</u>		Document Title:		Document Title:
Issuing Authority: <u>USA</u>		Issuing Authority:		Issuing Authority:
Document Number: <u>501195712</u>		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy): <u>5.13.2013</u>		Expiration Date (if any)(mm/dd/yyyy):		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): 6.21 (See instructions for exceptions.)

Signature of Employer or Authorized Representative <u>[Signature]</u>	Date (mm/dd/yyyy) <u>6.20.13</u>	Title of Employer or Authorized Representative <u>Acct Mgr</u>
Last Name (Family Name) <u>hool</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):
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If employer's current employment authorization has expired, provide the information for the document(s) that establish 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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EMPLOYEE INFORMATION

(Must Be Filled Out)

ENROLLMENT FORM - 10k PLAN

USE BLACK OR BLUE INK ONLY

Social Security Number **614-34-4777**
 Date of Birth **08/19/1986** Sex **M**
 Name **Yudith Gutierrez**
 Street Address **814 8th Ave**
~~Worthington, MN~~
 City **Worthington** State **MN** Zip **56187**
 Home Phone **605-951-1589**

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. _____

- You MUST enroll in the Medical Insurance Plan before adding STD or Term Life.
- Your coverage level for Term Life will be identical to your medical plan selection.

BENEFIT SELECTION

Weekly Rates

SELECT COVERAGE LEVEL

- Employee Only Employee + Family
 Employee +1 NO to all benefits.

If NO is checked, sign and date the bottom of the form and go no further.

MEDICAL

- YES \$20.91 Employee Only
 \$42.44 Employee + 1
 NO \$56.67 Employee + Family

DENTAL

- YES \$ 5.99 Employee Only
 \$11.98 Employee +1
 NO \$19.77 Employee + Family

TERM LIFE

- YES \$0.60 Employee Only
 \$0.90 Employee +1
 NO \$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 //
 Relationship: Spouse Domestic Partner Child

Name _____
 Social Security Number --
 Date of Birth //
 Relationship: Spouse Domestic Partner Child

Name _____
 Social Security Number --
 Date of Birth //
 Relationship: Spouse Domestic Partner Child

Name _____
 Social Security Number --
 Date of Birth //
 Relationship: Spouse Domestic Partner Child

BENEFICIARY INFORMATION

For Term Life and Accidental Death & Dismemberment please write in your Beneficiary information

NAME OF BENEFICIARY

RELATIONSHIP

Accidental Death & Dismemberment is part of the Medical benefit.

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

Signature *Yudith Gutierrez*

Date **08/10/2013**

Yudith Gutierrez

814 8th Ave Worthington MN 56187 (605)951-1589: Yudith.gz@gmail.com

Objectives: Seeking a position where I can utilize my skills, experience and education in the business field.

Skills:

- Bilingual-can speak, read, and write Spanish/English.
- Clerical skills include: Typing, Ten-key, data entry, filing and phone systems.
- Office machine operation and maintenance.
- Bookkeeping.
- QuickBooks and Peachtree software experience.
- Microsoft Excel, Word and PowerPoint.

Highlight of Qualifications:

- 6 years experience In Customer Service and data entry.
- One year experience In Account Receivable/sales.
- Possess strong communication, customer service and organizational skills.
- Responsible, reliable, and friendly.
- Pays close attention to detail and accuracy.

Relevant experience:

As a customer service representative:

- Answered telephones and screened calls.
- Research Information.
- Courteously provided information and customer assistance.
- Consistently surpassed sales goals/ developed highly effective leadership ability.
- Adhered to security and audit procedures.
- Performed routine office and clerical duties and maintained operational quality and standards.
- Provided exceptional customer service
- Maintained acceptable balancing record per established standards.
- Helped customers and businesses with their accounts.

As an accounts receivable/sales representative

- Updated and maintain customer accounts using Peachtree software.
- Account collection by phone, e-mail, and mail.
- Managed over 100 accounts and updated their data as needed.
- Sent statements to customers and independent distributors every month.
- Processed sales orders, sales invoices, and purchase orders.
- Prepared monthly reports.
- Filed charge, cash, and paid Invoices daily.
- Revised over 400 invoices manually everyday using ten-key machines.
- Received checks from customers and posted payments into their accounts.

Work history:

2009-2013	Customer Service Representative	Bank of the west.
2008-2009	Accounts Receivable /Sales	Candies Tolteca Corp.
2006-2008	Sales Associate	Mervy's Retail Store.

Education:

San Joaquin Valley College- **Associate of science Degree** in Business Administration.
Fresno City College-General Education.

References upon request.

222483552



402 W County Rd D
St. Paul, MN 55112
(651) 636-7466
(800) 832-3244

STEP 1

To be completed by COLLECTOR or EMPLOYER REPRESENTATIVE Account # 42687

A. Employer Name, Address, I.D. No. B. MRO Name, Address, Phone and Fax No. LAB ACCESSION NO.

CORPORATE MANAGEMENT GROUP
ATTN: TJNA KROL
12000 N WASHINGTON ST STE 290
THURSDAY, CO 80243
P: 303-950-1425 F: 303-736-7767

LAB ACCESSION NO. 14008

Account # 42687 Donor I.D. 614344777

C. Donor Name (Last, First) Gutierrez Judith Donor Daytime Phone 6059511589

D. Reason for Test Pre-employment Random Reasonable Suspicion/Cause Return To Duty Follow-up Post Accident Other (Specify)

E. Collection Site Name P, Parkstone County Medical Center 916 4th Ave Parkstone MN 56149 Collector Phone No. 5078256166 Collector Fax No. 5078256081

F. Test(s) Ordered 88534 88534 88537 OTHER TEST CODE:

STEP 2: COMPLETED BY COLLECTOR Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? Yes No, Enter Remark Specimen Collection: Split Single None Provided (Enter Remark) Observed (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements. Signature of Collector: [Signature] Date: 06132013 Time of Collection: 1030 AM SPECIMEN BOTTLE(S) RELEASED TO: UPS Local Courier Other FedEx

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

Signature of Donor: [Signature] Signature of Collector: Judith Gutierrez Date: 06/13/13 Daytime Phone No. (605) 951-1589 Evening Phone No. () Date of Birth: 08/19/1986

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable requirements, my determination/verification is: NEGATIVE POSITIVE TEST CANCELLED DILUTE REFUSAL TO TEST BECAUSE: ADULTERATED SUBSTITUTED

REMARKS Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.)

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable requirements, my determination/verification RECONFIRMED FAILED TO RECONFIRM - REASON

Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.)



722483552



402 W County Rd D
St. Paul, MN 55112
(651) 636-7466
(800) 832-3244

STEP 1

To be completed by **COLLECTOR**
or **EMPLOYER REPRESENTATIVE** Account # 42869

A. Employer Name, Address, I.D. No.

CORPORATE MANAGEMENT GROUP
ATTN: TINA KRUL
12000 N WASHINGTON ST STE 290
THORNTON, CO 80241
P: 303-920-1425 F: 303-736-7767

B. MRO Name, Address, Phone and Fax No.

LAB ACCESSION NO.

Account #

4 2 8 6 9

Donor I.D.

614344777

Donor Name
(Last, First)

Gutierrez Judith

Donor
Daytime
Phone

6059511589

D. Reason for Test

- Pre-employment
- Random
- Reasonable Suspicion/Cause
- Return To Duty
- Follow-up
- Post Accident

Other (Specify)

E. Collection Site Name

Pipestone County Medical Center
916 4th Ave
Pipestone MN 56149

Collector
Phone No.

5078256166

Collector
Fax No.

5078256081

F. Test(s)
Ordered

- 88544 5 PANEL
- 88534 9 PANEL
- 88537 10 PANEL
- OTHER TEST CODE:

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? Yes No, Enter Remark

Specimen Collection:

- Split
- Single
- None Provided (Enter Remark)
- Observed (Enter Remark)

14008

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable requirements.

X Jane C. Stevens
Signature of Collector
Jane C. Stevens
(PRINT) Collector's Name (First, MI, Last)

Time of
Collection 1030 AM PM
Date 06/13/2013

SPECIMEN BOTTLE(S) RELEASED TO:

- Name of Delivery Service Transferring Specimen to Lab
- UPS Local Courier
- Other FedEx

STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

X Judith Gutierrez
Signature of Donor

Judith Gutierrez
(PRINT) Donor's Name (First, MI, Last)

06/13/13
Date (Mo./Day/Yr.)

Daytime Phone No. (605) 951-1589

Evening Phone No. ()

Date of Birth 08/19/1986
Mo. Day Yr.

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable requirements, my determination/verification is:

- NEGATIVE POSITIVE TEST CANCELLED DILUTE
- REFUSAL TO TEST BECAUSE: ADULTERATED SUBSTITUTED

REMARKS

X _____
Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) _____
Date (Mo./Day/Yr.) _____

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable requirements, my determination/verification

- RECONFIRMED FAILED TO RECONFIRM - REASON

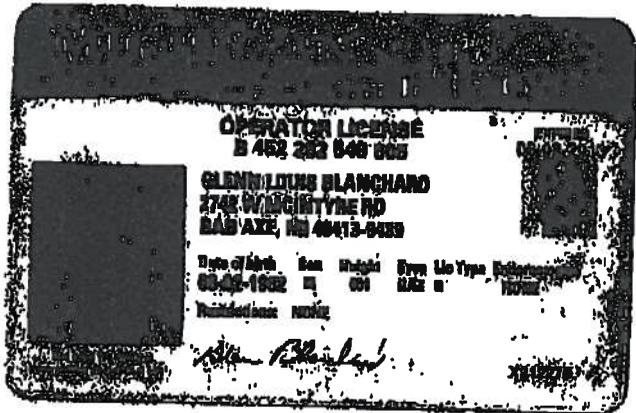
X _____
Signature of Medical Review Officer (PRINT) Medical Review Officer's Name (First, MI, Last) _____
Date (Mo./Day/Yr.) _____





#: 509821696

exp: May. 13. 2023



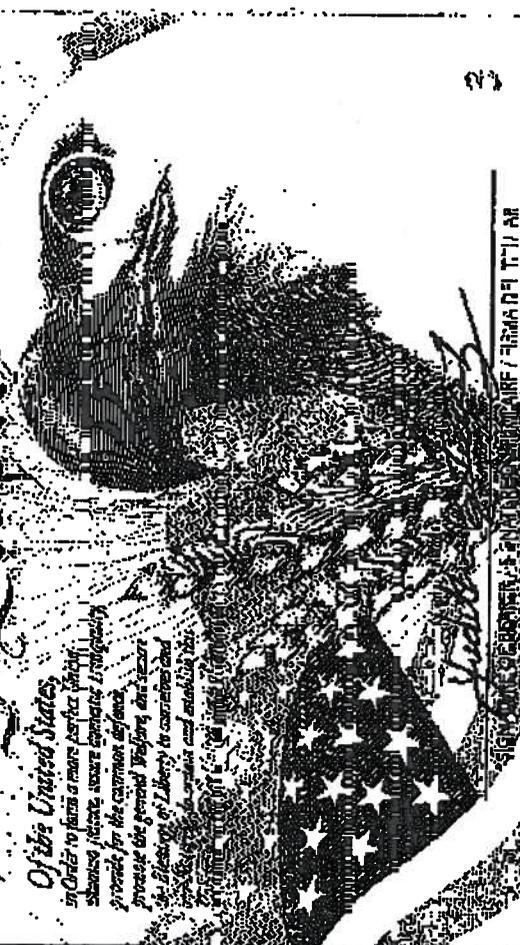
Back of the Was: 507-376-6002

No. 061

We the People

Of the United States

In Order to form a more perfect Union, to establish Justice, insure domestic Tranquillity, provide for the common defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, we the People of the United States do hereby constitute and establish this Constitution.



93

UNITED STATES OF AMERICA

FOR THE
PASSPORT

UNITED STATES OF AMERICA

We the People

*Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America.*



Judith [Signature]

3

SIGNATURE / FIRMA DEL TITULAR

PASS-BOEK
PASSEPORT
PASAPORTE

UNITED STATES OF AMERICA



Surname / Nombre
GIVIO MARIANA GONZALEZ MARTINEZ
GONZALEZ
Nationality / Nacionalidad / Nacionalidade
UNITED STATES OF AMERICA
20 Aug 1984
Date of issue / Date de delimitation / Data de emissao
22 OCT 2012
Department of State
SANTIAGO, CHILE

We the People

Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do hereby ordain and establish this
Constitution for the United States of America.



Judith Gutierrez
SIGNATURE / FIRMA DEL TITULAR

3

PASSPORT
PASSEPORT
PASAPORTE

UNITED STATES OF AMERICA



Surname / Nom / Apellido
GUTIERREZ
Given Name / Prápono / Nombre
JUDITH
Nationality / Nacionalidad / Nacionalidad
UNITED STATES OF AMERICA
Date of Birth / Fecha de Nacimiento / Fecha de Nacimiento
19 Aug 1986
Place of Birth / Lugar de Nacimiento / Lugar de Nacimiento
MEXICO
Date of issue / Fecha de expedición / Fecha de expedición
22 Oct 2017



P<USA<GUTIERREZ<JUDITH<MEX<19AUG1986<22OCT2017<21OCT2022<SEE PAGE 2<5160146

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security
E-Verify

Report Prepared: 06/21/2013
Page: 1 of 1

Case Verification Number: 2013172142415GJ

Case Information:**Employee Information:**

Last Name:	gutierrez	First Name:	yudith
Middle Initial:		Maiden Name:	
Social Security Number:	*** ** 4777	Date of Birth:	08/19/1986
Citizenship Status:	A citizen of the United States		

Document Information:

List A Document:	U.S. Passport or Passport Card		
Passport or Passport Card Number:	501125712	Document Expiration Date:	05/13/2023
Alien Number:		I-94 Number:	

Additional Information:

Hire Date:	06/21/2013	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CKRO8357	Submitted On:	06/21/2013

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:

Closed By:

Closed On:

SENSITIVE BUT UNCLASSIFIED