



SENSITIVE BUT UNCLASSIFIED

**Case Verification Number: 2018085162601VN**

Report Prepared: 03/26/2018

**Company Information**

---

Company ID: 47429

Company Name: Employer Solutions Staffing Group

**Employee Information**

---

Last Name: Nurse

First Name: Daniel

Date of Birth: 11/30/1980

Social Security Number: \*\*\* \*\* 4144

Hire Date: 03/26/2018

Citizenship Status: A citizen of the United States

**Document Information**

---

List B Document: Driver's license or ID card issued by a U.S. state or outlying possession

List C Document: Social Security Card

Document Name: Driver's license

Document State: Minnesota

Driver's License or ID Card Number:

Document Expiration Date: 11/30/2019

**Case Status Information**

---

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 03/26/2018

Case Submitted By: ZZEP3284

Closed On: 03/26/2018

Closed By: ZZEP3284

Closure Statement: The employee continues to work for the employer after receiving an Employment Authorized result.

SENSITIVE BUT UNCLASSIFIED



**Employment Eligibility Verification**  
**Department of Homeland Security**  
**U.S. Citizenship and Immigration Services**

**USCIS**  
**Form I-9**  
 OMB No. 1615-0047  
 Expires 08/31/2019

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ 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) <b>NURSE</b>		First Name (Given Name) <b>DANIEL</b>		Middle Initial <b>A</b>	Other Last Names Used (if any) <b>NA</b>	
Address (Street Number and Name) <b>1650 IDAHE</b>			Apt. Number <b>10</b>	City or Town <b>NEWPORT</b>		State <b>MN</b>
Date of Birth (mm/dd/yyyy) <b>11-30-80</b>		U.S. Social Security Number <b>580-21-4144</b>		Employee's E-mail Address <b>NURSEDAN31@GMAIL.COM</b>		Employee's Telephone Number <b>651-500-9692</b>

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

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

<input checked="" type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions)
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (See Instructions)

*Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.*

1. Alien Registration Number/USCIS Number: \_\_\_\_\_  
 OR  
 2. Form I-94 Admission Number: \_\_\_\_\_  
 OR  
 3. Foreign Passport Number: \_\_\_\_\_  
 Country of Issuance: \_\_\_\_\_

QR Code - Section 1  
 Do Not Write In This Space

Signature of Employee <b>X Daniel Nurse</b>	Today's Date (mm/dd/yyyy) <b>3-26-18</b>
---	--

**Preparer and/or Translator Certification (check one):**  
 I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's 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



**MINNESOTA**  
**DRIVER'S LICENSE**  
**COMMERCIAL**



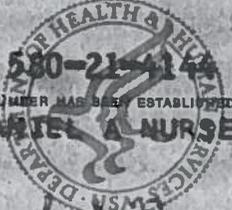
**DANIEL ANDRAE NURSE**  
1860 10TH AVE APT 10  
NEWPORT, MN 55088

Date of Birth **11-30-1990**  
Sex **M** Eyes **BRN** Class **A**  
Height **6-1** Weight **185**  
ISSUED **06-2016** EXPIRES **11-30-2019**

*Daniel Nurse*

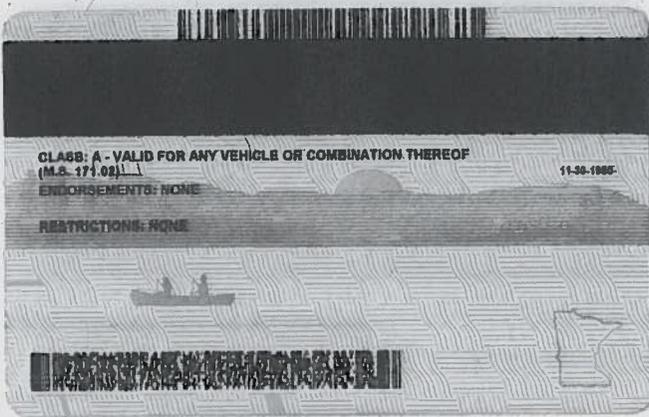
**E385053774816**

**SOCIAL SECURITY**



**580-21-4144**  
THIS NUMBER HAS BEEN ESTABLISHED FOR  
**DANIEL A NURSE**

*Daniel A Nurse*  
SIGNATURE



Do not laminate this card.

This card is invalid if not signed by the number holder unless health or age prevents signature.

Improper use of this card and/or number by the number holder or any other person is punishable by fine, imprisonment or both.

This card is the property of the Social Security Administration and must be returned upon request. If found, return to:

**SSA-ATTN: FOUND SSN CARD**  
P.O. Box 17087 Baltimore Md. 21203

Contact your local Social Security office for any other matter regarding this card.

**Department of Health and Human Services**  
Social Security Administration  
Form OA-702 (4-84)

**B43251767**



employer solutions staffing group<sub>llc</sub>

# New Hire Application

**Personal Data-- PLEASE PRINT LEGIBLY IN INK**

Last Name NURSE First Name DANIEL Middle Initial A

Street Address 1650 10TH AVE APT 10 Apt/Ste \_\_\_\_\_

City/State/Zip NEWPORT Social Security Last Four XXX-XX-4144

Phone Number 651-500-9692 Email Address NURSEDAN31@GMAIL.COM

Staffing Agency/Recruitment Partner \_\_\_\_\_

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

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

**Applicant Certification and Authorization**

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

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

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

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

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

X DANIEL NURSE  
Name (Print or type)

X Daniel Nurse  
Applicant's Signature

3-26-18  
Date

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

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

# Form W-4 (2017)

**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 2017 expires February 16, 2018. 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 can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

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

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

The exceptions don't apply to supplemental wages greater than \$1,000,000.

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

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

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

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

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 605 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for yourself if no one else can claim you as a dependent . . . . . **A** \_\_\_\_\_

**B** Enter "1" if:   
 • You're single and have only one job; or   
 • You're married, have only one job, and your spouse doesn't 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 \$2,000 of child or dependent care expenses for which you plan to claim a credit . . . . . **F** \_\_\_\_\_   
 (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**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 \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children.   
 • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child. **G** \_\_\_\_\_

**H** Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶ **H** \_\_\_\_\_

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

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

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <span style="font-size: 2em; font-weight: bold;">2017</span>	
▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.					
1 Your first name and middle initial DANIEL A		Last name NURSE		2 Your social security number 580-21-4144	
Home address (number and street or rural route) 1650 10TH AVE APT 10			3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code NEWPORT MN 55055			4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5 0	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶				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.) ▶ X Daniel Nurse				Date ▶ 3-26-18	
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)			9 Office code (optional)		10 Employer identification number (EIN)



employer solutions staffing group

### 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.

<b>SECTION 1 BASIC INFORMATION</b>		
Employee Name <b>DANIEL NURSE</b>	SSN# (last 4 digits) <b>4144</b>	Effective Date

<b>SECTION 2 PAYROLL ELECTION</b>	
<input checked="" type="checkbox"/> <b>Direct Deposit</b> (Please complete Sections 3 and 5 below)	<input type="checkbox"/> <b>Paper Check</b> (Option available to GA NH and NY residents only)
<input type="checkbox"/> <b>Payroll Debit Card</b> (Please complete Sections 4 and 5 below)	

<b>SECTION 3 DIRECT DEPOSIT</b>	
<input type="checkbox"/> Update Bank Account	<p><i>Note: Direct Deposit accounts may take up to 7 days to be activated.</i></p> <p>I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.</p> <p>Initial _____ Date _____</p>
Bank Name: <b>ASHLAND CREDIT UNION</b>	
Routing# <b>242175557</b>	
Account# <b>2000 8915 3</b>	
Account Type: <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other _____	

- 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.

<b>CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)</b>			
First Name	M.I.	Last Name	Date of Birth
Street Address (PO BOX NOT ACCEPTABLE)			Social Security#
City	State	Zip	Cell Phone (mobile)

<b>RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)</b>	
Payroll Debit Card Routing #	Payroll Debit Card Account #

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

Employee's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

<b>SECTION 5 AUTHORIZATION</b>	
I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s). <b>* E-mail is required for pay stub information.</b>	
*E-mail: _____ @ _____	this information will only be used to send your paystubs electronically
Employee's Signature: <u>X</u> <b>Daniel Nurse</b>	Date: <b>3-26-18</b>

EMPLOYER SOLUTIONS STAFFING GROUP  
BACKGROUND CHECK AUTHORIZATION

Employee Name: DANIEL ANDRAE NURSE  
(First) (Middle) (Last)

Former Name(s) and Dates Used: \_\_\_\_\_

Current Address Since: 1030 10TH AVE APT 10 NEWPORT MN 55055  
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: 7602 HINTON AVE APT 6 COTTAGE GROVE MN 55016  
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: 371 STRAWBERRY HILL ST. CROIX USVI 00823  
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: 580 21 4144 DOB: 11-30-80

Phone Number: 651-500-9692

Driver's License Number/State: E 38505 3774816

The information contained in this application is correct to the best of my knowledge.

I hereby authorize Employer Solutions Staffing Group, LLC and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Employer Solutions Staffing Group, LLC or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Employer Solutions Staffing Group, LLC and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: X Daniel Nurse Date: 3-26-18

**Notice to CA, MN, and OK Residents:**

Please check the box below if you wish to receive a copy of a consumer report that is requested.

I wish to receive a copy of any Background Check Report on me that is requested.

## EMERGENCY CONTACT INFORMATION

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

Employee Name: DANIEL NURSE

Address: 1650 10TH AVE APT 10 NEWPORT MN 55055

Home Phone: 651-500-9692

<b>EMERGENCY CONTACTS</b>	
Please list two people (in priority order) who could be contacted in case of an emergency	
<b>Contact #1</b>	Home Phone:
Name: <u>DALE PRIME</u>	Cell Phone: <u>1-952-239-9514</u>
Relationship: <u>SISTER</u>	Work Phone:
<b>Contact #2</b>	Home Phone:
Name:	Cell Phone:
Relationship:	Work Phone:

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

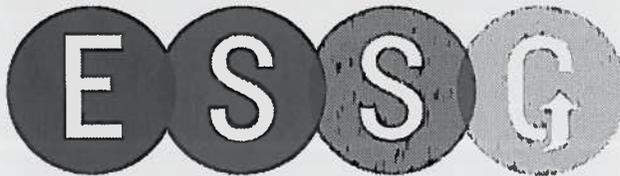
---

---

---

---

---



employer solutions staffing group LLC

---

**STATEMENT OF CONFIDENTIALITY**

This agreement made this 26 day of March, 2011, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Daniel hereafter referred to as "employee".

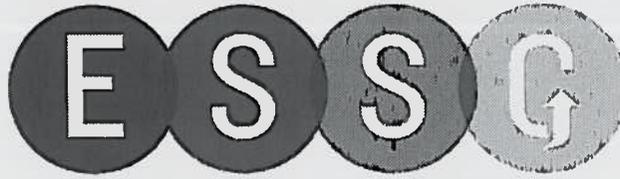
**WITNESSETH:**

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.

X Daniel Nurse  
Employee Signature

[Signature]  
Employer Solutions Staffing Group LLC, Representative



employer solutions staffing group<sub>uc</sub>

## **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.

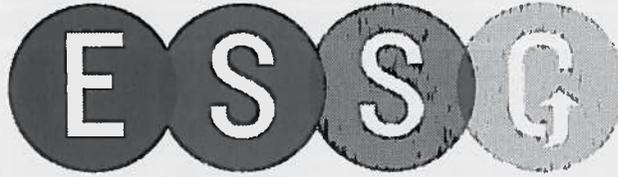
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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:  Daniel Nurse

Printed Name: DANIEL NURSE



employer solutions staffing group.

## Important/Importante

### LOST OR STOLEN PAYCHECKS

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

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

### CHEQUES DE PAGO PERDIDOS O ROBADOS

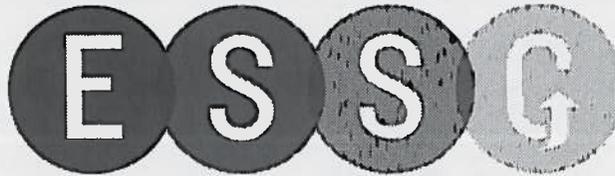
Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted,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

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

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): DANIEL NURSE

Signature/Firma: Daniel Nurse



employer solutions staffing group<sub>llc</sub>

## **ESSG WORKPLACE SAFETY POLICY**

It is ESSG's policy that all employees should be able to enjoy a hazard free and safe work environment. It is ESSG's duty to:

- (1) Ensure that its clients provide you with a workplace free from serious recognized hazards and comply with standards, rules and regulations issued under the OSH Act.
- (2) Ensure that its clients perform a job hazard assessment in order to identify and eliminate potential safety and health hazards and to determine necessary training and protections for employees at the facility.
- (3) Make sure employees have and use safe tools and equipment.
- (4) Establish or update operating procedures and communicate them so that employees follow safety and health requirements.
- (5) Provide safety training in a language and vocabulary workers can understand.

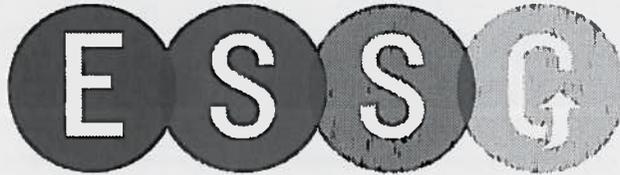
ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

To help ensure a safe workplace, you have certain responsibilities too, which include the following:

- Responsibility to work in compliance with OSHA laws and regulations
- Responsibility to use personal protective equipment and clothing as directed by the host employer
- Responsibility to report workplace hazards and dangers
- Responsibility to work in a manner as required by the employer and use the prescribed safety equipment.

You have the following basic rights:

- Right to refuse unsafe work
- Right to know or be informed about actual and potential dangers in the workplace
- Right to review copies of appropriate standards, rules, regulations and requirements that the host employer is required to have available at the workplace.



employer solutions staffing group<sub>llc</sub>

---

**Acknowledgement of Receipt of Workplace Safety Policy**

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

I also agree that if at any time during my employment I am believe that I am working in an unsafe or dangerous work environment, I will immediately contact my supervisor, manager, director or ESSG's Safety Director at 952.835.1288/1.866.496.7573 in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

DANIEL NURSE

Employee's Signature:

X Daniel Nurse Date: 3-26-18



employer solutions staffing group.

Leveraging Resources in a Changing Market

---

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

*According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment. This paragraph applies only if, at the time of beginning of employment with the staffing service, the applicant signed and was provided a copy of a separate document written in clear and concise language that informed the applicant of this paragraph and that unemployment benefits may be affected.*

It is your responsibility to contact ESSG through Corporate Management Group (for instance, by calling 303-920-1425 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

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

Daniel Nurse  
Employee Signature:

3-20-18  
Date:

DANIEL NURSE  
Employee (please print your name here)

**Telephone: 303-920-1425  
12000 N. Washington Street Suite 350  
Thornton, CO 80241**

**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

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

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

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

X DANIEL NURSS  
Individual's Name

3-26-18  
Date

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

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

OMB No. 1545-1600

► Information about Form 8850 and its separate instructions is at [www.irs.gov/form8850](http://www.irs.gov/form8850).

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

Your name DANIEL NURSE Social security number ► 580-21-4144  
Street address where you live 1650 10TH AVE APT 1A  
City or town, state, and ZIP code NEWPORT MN 55055  
County WASHINGTON Telephone number 651-500-9692  
If you are under age 40, enter your date of birth (month, day, year) 11-30-80

- 1  Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2  Check here if any of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
  - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
  - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
  - I am at least age 18 but not age 40 or older and I am a member of a family that:
    - a. Received SNAP benefits (food stamps) for the past 6 months; or
    - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
  - During the past year, I was convicted of a felony or released from prison for a felony.
  - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
  - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3  Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4  Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5  Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6  Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; or
  - Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; or
  - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.
- 7  Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

### 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 ► Daniel Nurse

Date 3-26-18

**EMPLOYER SECTION:**

<b>Client:</b>	<b>Company:</b>	
<b>Location:</b>	<b>Position:</b>	<b>Starting Wage: \$</b>

**EMPLOYEE SECTION:**

<b>First Name: Last Name:</b> DANIEL NURSE	<b>Suffix:</b>	<b>Street Address:</b> 1050 10TH AVE APT 10	<b>City/State:</b> NEWPORT, MN	<b>Zip:</b> 55055
<b>SS#:</b>	<b>Date of Birth:</b> 11-30-80	<b>Age:</b> 37	<b>Have you worked for this company before?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<b>If yes, location:</b>

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

	Yes	No
<b>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.)</b> Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>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.)</b> Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?</b> Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. <i>*If you checked yes please provide a copy of your SSI documentation.</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>4. Have you received any type of vocational rehabilitation services within the past two years?</b> 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: _____ <i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>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.)</b> Dates of Service - From: _____ To: _____ Branch of Service: _____ <b>Are you entitled to or are you receiving compensation for a service-connected disability?</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6. Have you been unemployed at any time during the last 12 months?</b> If yes, dates of unemployment - From: _____ To: _____ <b>Did you receive unemployment compensation at any point during your unemployment?</b> If yes, in which state did you receive unemployment compensation? _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</b> 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"/>
<b>Additional Tax Credits</b>		
<b>IEC (Native American): Are you or your spouse a member of a Native American Tribe?</b> <i>If you checked yes please provide a copy of your CDIB card.</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>CA Residents:</b> <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?		
<b>SC Residents:</b> <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:  Daniel Nurse  Date:  3-26-18



# Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION \_\_\_\_\_ Rehire Date \_\_\_/\_\_\_/\_\_\_

## ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION		PRINT USING BLACK or BLUE INK (Must Be Filled Out)	
Name <u>Daniel Nurse</u>	Social Security #	Home Phone	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address			Apt. #
City	State	Zip	Date of Birth / /

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?	
<input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, please continue.	
Medicare Health Insurance Claim Number (HICN)	Medicare Effective Date
Name of Covered Person (s):	
1.	2.
	3.

C. LIMITED BENEFITS PLAN SELECTION		Payroll Deducted Weekly Rates			
<p>You <b>MUST</b> select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.</p>					
SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL <sup>1</sup>	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY <sup>2</sup>
Employee Only <input type="checkbox"/>	\$20.25	\$6.17	\$2.42	\$0.60	\$4.20
Employee + 1 <input type="checkbox"/>	\$41.10	\$12.34	\$4.92	\$0.90	
Employee + Family <input type="checkbox"/>	\$54.88	\$20.36	\$6.56	\$1.80	
<input checked="" type="checkbox"/> NO to ALL Benefits <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				

<sup>1</sup>This coverage is not available to residents of NH, HI, or PR. <sup>2</sup>STD is not available to persons who work in CA, HI, NJ, NY, or RI.

**For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

D. REQUIRED DEPENDENT INFORMATION				
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. REQUIRED SIGNATURE		YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE
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.		
DATE <u>3/26/1918</u>	SIGNATURE <u>Daniel Nurse</u>	

\*This Plan DOES NOT Alleviate the Individual Mandate Penalty\*

This is an Essential StaffCARE Enrollment Form.



# Enhanced MEC\_Plan 1



Benefits Enrollment Form  New Employee  Rehire  Rehire Date

Employee Information

Name (First and Last) <b>Daniel Nurse</b>	Social Security Number
--	------------------------

Address	City	State	Zip Code
---------	------	-------	----------

Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Divorced	Date of Birth	Date of Hire
---	--	---------------	--------------

Phone Number:	Email Address:
---------------	----------------

**Please Select Desired Coverage:**

Employee Only - \$24.00/Week   
 Employee+Spouse - \$38.00/Week   
 Employee+Child(ren) - \$36.00/Week   
 Family - \$63.00/Week

Dependent

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Dependent

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Dependent

First Name	M.I.	Last Name	Social Security #	Birth Date	Sex	Relationship
					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

EFF. DATE
EFF. DATE
EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

## IF ENROLLING - YOU MUST SIGN HERE

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

EMPLOYEES DECLINING  I am DECLINING coverage

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

## IF DECLINING- YOU MUST SIGN HERE

Employee Signature **Daniel Nurse** Date **3-26-18**

Employer Solutions Staffing Group Health Benefits Team  
 PO Box 48270  
 Minneapolis, MN 55344  
 Phone: 952-767-9519 Fax: 952-767-9515  
 Email: Health@employersolutionsgroup.com