

employer solutions staffing group

# New Hire Application

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

Last Name Groman First Name DeKaylen Middle Initial S  
 Street Address 4287 2482 Cobble Hill alcove apt B Apt/Ste \_\_\_\_\_  
 City/State/Zip Woodbury, MN, 55225 Social Security Last Four XXX-XX-4695  
 Phone Number 612-554-6132 Email Address KaylenGroman84@gmail.com  
 Staffing Agency/Recruitment Partner Corporate Management Group - Mari A.

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.

DeKaylen Groman  
 Name (Print or type)

Applicant's Signature

8/22/2018  
 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 (2018)

**Future developments.** For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

**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.** You may claim exemption from withholding for 2018 if both of the following apply.

- For 2017 you had a right to a refund of all federal income tax withheld because you had no tax liability, and
- For 2018 you expect a refund of all federal income tax withheld because you expect to have no tax liability.

If you're exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

## General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

**Filers with multiple jobs or working spouses.** If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

**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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to find out if you should adjust your withholding on Form W-4 or W-4P.

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

## Specific Instructions

### Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

**Line C. Head of household please note:** Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

**Line E. Child tax credit.** When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

**Line F. Credit for other dependents.** When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form <b>W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074	
		▶ Whether you're 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.		2018	
1 Your first name and middle initial <b>DeKayla S</b>		Last name <b>Cerumian</b>		2 Your social security number <b>428-83-4545</b>	
Home address (number and street or rural route) <b>4280800955 2482 Cobble Hill</b>		3 <input checked="" type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."			
City or town, state, and ZIP code <b>Woodbury MN 55125</b>		4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1218 for a replacement card. <input type="checkbox"/>			
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)				5	
6 Additional amount, if any, you want withheld from each paycheck				6 \$ 1	
7 I claim exemption from withholding for 2018, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here.					
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.)		Date		8/22/2018	
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.) <b>CMG: 404 Broadway Ave St. Paul Park MN 55071</b>		9 First date of employment <b>08/25/2018</b>		10 Employer identification number (EIN) <b>-</b>	

## EMERGENCY CONTACT INFORMATION

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

Employee Name: DeKayla Gruman

Address: 2482 Cobble Hill alcove apt 6 woodbury MN

Home Phone: 612-89-6132

### EMERGENCY CONTACTS

Please list two people (in priority order) who could be contacted in case of an emergency

Contact #1	
Name: <u>Cheryl Shaw</u>  Relationship: <u>Mother</u>	Home Phone: <u>-</u>  Cell Phone: <u>507-338-3964</u>  Work Phone: <u>-</u>
Contact #2	
Name: <u>Dimesha Gruman</u>  Relationship: <u>Sister</u>	Home Phone: <u>-</u>  Cell Phone: <u>612-288-5132</u>  Work Phone: <u>-</u>

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

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*This information will remain confidential and will only be used in the case of an emergency.*



employer solutions staffing group

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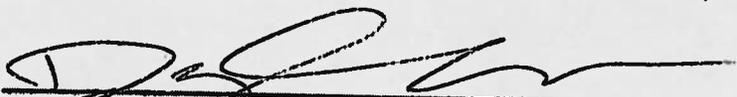
**STATEMENT OF CONFIDENTIALITY**

This agreement made this 22 day of August, 2018, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Derek Can 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



## **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.

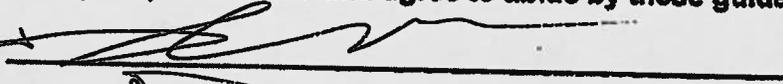
Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

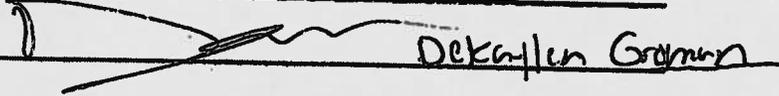
Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

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: 

DeKalen Gorman



**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>Groman</b>		First Name (Given Name) <b>DeKallan</b>		Middle Initial <b>S</b>	Other Last Names Used (if any)	
Address (Street Number and Name) <b>2482 Cobble Hill alcove # B</b>			Apt. Number <b>B</b>	City or Town <b>Wardbury</b>		State <b>MA</b>
Date of Birth (mm/dd/yyyy) <b>02/18/1997</b>	U.S. Social Security Number <b>428-873-4645</b>		Employee's E-mail Address <b>Kaylegroman84@gmail.com</b>		Employee's Telephone Number <b>617-89-6132</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):

1. A citizen of the United States

2. A noncitizen national of the United States (See instructions)

3. A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_

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 Today's Date (mm/dd/yyyy) **8/22/2018**

**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

**Employer Completes Next Page**



**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

**Section 2. Employer or Authorized Representative Review and Verification**

*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")*

<b>Employee Info from Section 1</b>	<b>Last Name (Family Name)</b> GROMAN	<b>First Name (Given Name)</b> DEKAYLEN	<b>M.I.</b> S	<b>Citizenship/Immigration Status</b> US Citizen 1
<b>List A</b>		<b>OR</b>		<b>List B</b>
<b>Identity and Employment Authorization</b>		<b>AND</b>		<b>List C</b>

<b>Document Title</b>	<b>Document Title</b> Social Security Card	<b>Document Title</b> Student I.D.
<b>Issuing Authority</b>	<b>Issuing Authority</b> Social Security Administration	<b>Issuing Authority</b> St. Paul College
<b>Document Number</b>	<b>Document Number</b> 42B-83-4595	<b>Document Number</b> 13565849
<b>Expiration Date (if any) (mm/dd/yyyy)</b>	<b>Expiration Date (if any) (mm/dd/yyyy)</b> N/A	<b>Expiration Date (if any) (mm/dd/yyyy)</b> N/A
<b>Document Title</b>	<b>Additional Information</b>	
<b>Issuing Authority</b>		
<b>Document Number</b>		
<b>Expiration Date (if any) (mm/dd/yyyy)</b>		
<b>Document Title</b>		
<b>Issuing Authority</b>		
<b>Document Number</b>	QR Code - Section 2 A 3 Do Not Write In This Space	
<b>Expiration Date (if any) (mm/dd/yyyy)</b>		
<b>Document Title</b>		
<b>Issuing Authority</b>		
<b>Document Number</b>		
<b>Expiration Date (if any) (mm/dd/yyyy)</b>		

**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): 08/25/2018 (See instructions for exemptions)

<b>Signature of Employer or Authorized Representative</b> <i>M Anderson</i>	<b>Today's Date (mm/dd/yyyy)</b> 08/22/2018	<b>Title of Employer or Authorized Representative</b> Recruiter
<b>Last Name of Employer or Authorized Representative</b> Anderson	<b>First Name of Employer or Authorized Representative</b> Mari	<b>Employer's Business or Organization Name</b> EMPLOYER SOLUTIONS STAFFING GROUP LLC
<b>Employer's Business or Organization Address (Street Number and Name)</b> 7480 FLYING CLOUD DRIVE SUITE 200	<b>City or Town</b> EDEN PRAIRIE	<b>State</b> MN
		<b>ZIP Code</b> 55344

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

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>		
<b>Last Name (Family Name)</b>	<b>First Name (Given Name)</b>	<b>Middle Initial</b>	<b>Date (mm/dd/yyyy)</b>		
<b>C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.</b>					
<b>Document Title</b>		<b>Document Number</b>		<b>Expiration Date (if any) (mm/dd/yyyy)</b>	

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.

<b>Signature of Employer or Authorized Representative</b> <i>M Anderson</i>	<b>Today's Date (mm/dd/yyyy)</b> 08/22/2018	<b>Name of Employer or Authorized Representative</b> Mari Anderson
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**SAINT PAUL COLLEGE**  
A Community & Technical College



**Student**

**De'kaylen  
Groman**

**Issued On: 01/11/2018**  
**Tech ID: 13565849**

511340-455111V924

0075100

**235 Marshall Avenue**  
**Saint Paul, MN 55102**  
**651.846.1600**



**20409001787877**

A Member of the  
Minnesota State Colleges and Universities System



428-83-4595

THIS NUMBER HAS BEEN ESTABLISHED FOR

DEKAYLEN SHAQUESS  
GROMAN

*Dekaylen Shaquess Groman*  
SIGNATURE

07/18/2016

USA

G70376494



Social Security Administration  
Form SSA-3000 (08-2011)

This card belongs to the Social Security Administration and you must  
return it if we ask for it.  
If you find a card that isn't yours, please return it to:  
Social Security Administration  
P.O. Box 33008, Baltimore, MD 21290-3008  
For any other Social Security business information, contact your local  
Social Security office. If you write to the above address for any business  
other than returning a found card you will not receive a response.



**2018 Minnesota Employee Withholding Allowance/Exemption Certificate**

**Employees**

You must complete and give this form to your employer if you do any of the following:

- Claim fewer Minnesota withholding allowances than your federal allowances
- Claim more than 10 Minnesota withholding allowances
- Want additional Minnesota tax withheld from your pay each pay period
- Claim to be exempt from federal withholding or claim to be exempt from Minnesota withholding

Do not complete this form if you are claiming the same number of Minnesota allowances as federal and the number claimed is 10 or less.

Employee's first name and initial <u>D. Kayler</u>		Last name <u>Cramer</u>	Employee's Social Security number <u>428-83-4595</u>	
Permanent address <u>2482 Cobble Hill drive</u>			Marital status (check one box) <input checked="" type="checkbox"/> Single Married, but legally separated; or Spouse is a nonresident alien	
City <u>Wexbury</u>	State <u>MN</u>	ZIP code <u>55125</u>	<input type="checkbox"/> Married	
			<input type="checkbox"/> Married, but withhold at higher Single rate	

Employees: Read instructions on back, complete Section 1 OR Section 2, sign and give the completed form to your employer. (Do not complete both Section 1 and Section 2. Completing both sections will make the form invalid.)

**Section 1 — Determining Minnesota allowances**

Complete Section 1 if you claim fewer Minnesota allowances than your federal allowances, AND/OR if you want additional Minnesota withholding deducted each pay period.

- 1 Total number of federal allowances claimed on federal Form W-4 ..... 1 1
- 2 Total number of Minnesota allowances (line 2 cannot be more than line 1) ..... 2 \_\_\_\_\_
- 3 Additional Minnesota withholding you want deducted each pay period ..... 3 \$ \_\_\_\_\_

**Section 2 — Exemption from Minnesota withholding**

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding (see Section 2 instructions for qualifications). If applicable, check one box below to indicate the reason why you believe you are exempt:

- I meet the requirements and claim exempt from both federal and Minnesota income tax withholding.
- Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding because I had no Minnesota income tax liability last year, I received a refund of all Minnesota income tax withheld, AND I expect to have no Minnesota income tax liability this year.
- My spouse is a military service member assigned to a military location in Minnesota, my domicile (legal residence) is in another state, AND I am in Minnesota solely to be with my spouse. My state of domicile is \_\_\_\_\_
- I am an American Indian living and working on a reservation.
- I am a member of the Minnesota National Guard or an active duty U.S. military member and claim exempt from Minnesota withholding on my military pay.
- I receive a military pension or other military retirement pay as calculated under Title 10, 1401 through 1414, 1447 through 1455, and 12733 and claim exempt from Minnesota withholding on this retirement pay.

I certify that all information provided in Section 1 OR Section 2 is correct. I understand there is a \$500 penalty for filing a false withholding allowance/exemption certificate.

Employee's signature <u>D. Kayler</u>	Date <u>8/22/18</u>	Daytime phone <u>612-519-6132</u>
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Employees: Give the completed form to your employer.

**Employers**

If you are required to send a copy of this form to the Department of Revenue (see Instructions), you must enter the employer information below and mail this form to: Minnesota Revenue, Mail Station 6501, St. Paul, MN 55146-6501. (Incomplete forms are considered invalid.) A \$50 penalty may be assessed for each required Form W-4MN not filed with the department.

Keep a copy for your records.

Name of employer	Federal employer ID number (FEIN)	Minnesota tax ID number
Address	City	State ZIP code



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## **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.



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- **Right to request information about safety and health hazards in the workplace, appropriate precautions to take, and procedures to follow if involved in an accident or exposed to hazardous substances**
- **Right to gain access to relevant personal exposure and medical records.**

You can have your name withheld from the host employer and any other entity, by request, if you sign and file a written complaint. You can request to be advised of OSHA actions regarding a complaint, and request an informal review of any decision not to inspect the site or issue a citation. And, you can file a complaint if you are punished or discriminated against for acting as a "whistleblower" under the OSH Act or 13 other federal statutes for which OSHA has jurisdiction, or for refusing to work when faced with imminent danger of death or serious injury and there is insufficient time for OSHA to inspect. Retaliation or reprisal taken against anyone who has expressed concern about workplace safety is illegal.

If you believe that your right to a safe workplace has been violated, you can make a report to a manager of the host worksite employer and/or ESSG (by telephoning 952.835.1288/1.866.496.7573) and asking for the ESSG Safety Director. You can also contact OSHA directly with any concern. ESSG recognizes the serious nature of ensuring workplace safety will endeavor to protect any employee who may have been subjected to unsafe or hazardous worksite conditions.



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### Acknowledgement of Receipt of Workplace Safety Policy

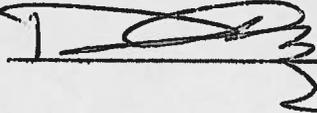
I certify that I have received a copy of Employer Solutions Staffing Group's ESSG WORKPLACE SAFETY POLICY. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at 952.835.1288/1.866.496.7573 with any 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)

Dekaylen Gorman

Employee's Signature:

 Date: 8/22/2018

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

OMB No. 1545-1500

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 DeKaylin Gromm Social security number ▶ 428-83-4595

Street address where you live 2482 Cobble Hill alcove apt 5

City or town, state, and ZIP code Woodbury MN 55125

County Washington County Telephone number 612-559-6132

If you are under age 40, enter your date of birth (month, day, year) \_\_\_\_\_

- 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 ▶ *DeKaylin Gromm*

Date 6/22/2018

**EMPLOYER SECTION:**

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

**EMPLOYEE SECTION:**

<b>First Name:</b> <u>Douglas</u>	<b>Last Name:</b> <u>Orman</u>	<b>Suffix:</b> <u>J</u>	<b>Street Address:</b> <u>2482 Cobble Hill</u>	<b>City/State:</b> <u>Westbury</u>	<b>Zip:</b> <u>95125</u>
<b>SSN:</b> <u>428-83-4595</u>	<b>Date of Birth:</b> <u>12/19/1997</u>	<b>Age:</b> <u>20</u>	<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
<p><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: _____</p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><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: _____</p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><b>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.</b></p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><b>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:</b> <input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input checked="" 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></p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><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></p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><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? _____</p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><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: _____</p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Additional Tax Credits</b>		
<p><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></p>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<p><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?</p>		
<p><b>SC Residents:</b> <input type="checkbox"/> Do you receive Family Independence Benefits?</p>		

**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: \_\_\_\_\_

Date: 8/22/18



**LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM**  
**Work Opportunity Tax Credit (WOTC) Program**

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

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

New Hire's Signature: \_\_\_\_\_

Date 8/22/2018

New Hire Name: Delanyia Gorman

Social Security Number: 428-83-4595

Employer Name: \_\_\_\_\_

Please check the statements below if they apply to you.

I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

I declare that I have been in a period of unemployment since \_\_\_\_\_  
(Enter start date)

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

**Public Burden Statement:**  
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

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

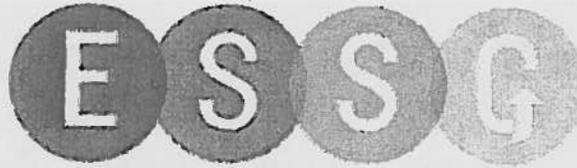
2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events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

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

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

8/22/2018  
Date

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



employer solutions staffing group, llc

## Important/Importante

### LOST OR STOLEN PAYCHECKS

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

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

### CHEQUES DE PAGO PERDIDOS O ROBADOS

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

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

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde):

Signature/Firma:

EMPLOYER SOLUTIONS STAFFING GROUP  
BACKGROUND CHECK AUTHORIZATION

Employee Name: DeKaylan S Graham  
(First) (Middle) (Last)

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

Current Address Since: 4282 Cobb Hill apart 6  
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: \_\_\_\_\_  
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: \_\_\_\_\_  
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: 428-83-4595 DOB: \_\_\_\_\_

Phone Number: 612-554-6132

Driver's License Number/State: \_\_\_\_\_

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: [Signature] Date: 8/22/2018

**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.

# Fixed Indemnity Medical Benefits Plan 2

VSI 219301-ESG-1 OFFICE USE ONLY LOCATION \_\_\_\_\_ Hire 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 \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

### B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS? Yes 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

You **MUST** 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.

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 <input type="checkbox"/>	\$6.17 <input type="checkbox"/>	\$2.42 <input type="checkbox"/>	\$0.60 <input type="checkbox"/>	\$4.20 <input type="checkbox"/>
Employee + 1 <input type="checkbox"/>	\$41.10 <input type="checkbox"/>	\$12.34 <input type="checkbox"/>	\$4.92 <input type="checkbox"/>	\$0.90 <input type="checkbox"/>	
Employee + Family <input type="checkbox"/>	\$54.88 <input type="checkbox"/>	\$20.36 <input type="checkbox"/>	\$6.56 <input type="checkbox"/>	\$1.80 <input type="checkbox"/>	
NO to ALL Benefits <input checked="" 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  M  F  Relationship  Spouse  Child  Domestic Partner

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M  F  Relationship  Spouse  Child  Domestic Partner

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M  F  Relationship  Spouse  Child  Domestic Partner

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M  F  Relationship  Spouse  Child  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 \_\_\_\_/\_\_\_\_/\_\_\_\_ ▶ SIGNATURE \_\_\_\_\_

Enhanced MEC\_Plan 1

Benefits Enrollment Form New Employee Rehire Rehire Date

Employee Information	
Name (First and Last)	Social Security Number
Address	City State Zip Code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input 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) - \$35.00/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	Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/>
Dependent				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/>
Dependent				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/>

Other coverage information including Med care/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 \_\_\_\_\_

EMPLOYEE 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 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 or parting with 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 *[Signature]* Date *8/22/2018*