employer solutions staffing group
Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405
Edina, MN 55439
Tel: 952.835.1288
www.esgstaffingsolutions.com

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Martinez **First Name** Denise **Middle Initial** M

Street Address 11844 Sherman Street **Apt/Ste** _____

City/State/Zip Northglenn, CO. 80233 **Social Security Last Four** XXX-XX-0820

Phone Number 720-569-8641 **Email Address** musicnote101@yahoo.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.

Denise Martinez	Denise Martinez	11/8/2016
Name (Print or type)	Applicant's Signature	Date

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

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	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 (2016)

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 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $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 do not apply to supplemental wages greater than $1,000,000.

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

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

Head of household. Generally, you 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. 505 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 2016. 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*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $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.

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

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2016

1 Your first name and middle initial: Denise M
Last name: Martinez
2 **Your social security number:** 523-15-0820

Home address (number and street or rural route): 11844 Sherman Street
3 ☒ Single ☐ Married ☐ 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: Northglenn, CO. 80233
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.** ► ☐

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 $ 0
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	7

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

Employee's signature
(This form is not valid unless you sign it.) ► Denise Martinez **Date** ► 11/8/2016

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)

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q Form **W-4** (2016)

This form cannot be used for employees hired prior to September 1, 2014.

Revision Date: 09/01/14
Expiration Date: 10/01/17

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

Employee Name: Martinez Denise M 5/14/1970
Last First Middle Date of Birth

Social Security Number: 523-15-0820 Date of Hire: _____(MM/DD/YYYY)

In accordance with § 8-2-122, C.R.S., within 20 calendar days after hiring the new employee listed above,

I affirm all four of the following by signing this form:

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

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

_____ _____(MM/DD/YYYY)
Signature of Employer (or Designated Representative) Date Signed by Employer

_____ _____
Business or Organization Name Employer Phone Number

The provision of false or fraudulent information on this form may subject the employer to a significant fine and/or additional penalties.

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

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

This mandatory affirmation is provided by the Colorado Division of Labor. Visit www.colorado.gov/cdle/evr for more information.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶**START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name (*Given Name*)	Middle Initial	Other Names Used (*if any*)
Martinez	Denise	M	

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code
11844 Sherman Street		Northglenn	CO.	80233

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
5/14/1970	523-15-0820	musicnote101@yahoo.com	(720)569-8641

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):

[X] A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (*mm/dd/yyyy*):
Denise Martinez	11/8/2016

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	Date (*mm/dd/yyyy*):

Last Name (*Family Name*)	First Name (*Given Name*)

Address (*Street Number and Name*)	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**For persons under age 18 who are unable to present a document listed above:**		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Employer Completes This Page

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Last Name, First Name and Middle Initial from Section 1: Martinez, Denise M.

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: CO Driver License		Document Title: Social Security Card
Issuing Authority:		Issuing Authority: State of CO		Issuing Authority: SSA
Document Number:		Document Number: 92-145-0307		Document Number: 523-15-0820
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: 05/14/2017		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: 11/08/2016 ***(See instructions for exemptions.)***

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Andrea Findley	11/08/2016	Admin. Assistant

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Findley	Andrea	EMPLOYER SOLUTIONS STAFFING GROUP LLC

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
7301 OHMS LANE SUITE 405	EDINA	MN	55439

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

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

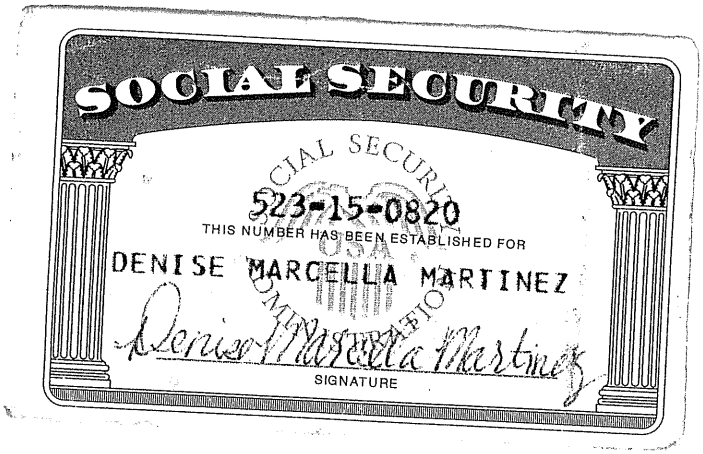
C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

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

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Colorado
Driver License
92-145-0307
Expires: 05-14-2017
Class: R
Issued: 06-16-2012
End:
DOB: 05-14-1970
Rest: V
Previous Type:
Ht: 5'05" Wt: 180
Eyes: BRO
Sex: F
Voter:
DENISE MARCELLA MARTINEZ
11844 SHERMAN STREET
NORTHGLENN, CO 80233


SOCIAL SECURITY
523-15-0820
THIS NUMBER HAS BEEN ESTABLISHED FOR
DENISE MARCELLA MARTINEZ
SIGNATURE

E-Verify

SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2016313162736NY

Report Prepared: 11/08/2016

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Martinez

First Name: Denise

Date of Birth: 05/14/1970

Social Security Number: *** ** 0820

Hire Date: 11/08/2016

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: Colorado

Driver's License or ID Card Number:

Document Expiration Date: 05/14/2017

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 11/08/2016

Case Submitted By: AFIN3846

Closed On: 11/08/2016

Closed By: AFIN3846

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

SENSITIVE BUT UNCLASSIFIED

For more information contact us at 888-464-4218 or E-Verify@dhs.gov.

U.S. Department of Homeland Security

U.S. Citizenship and Immigration Services

Enable Permanent Tooltips

Accessibility

Download Viewers

Authorization

Authorization: By signing below, you authorize: (a) backgroundchecks.com ("BGC") to request information about you from any public or private information source; (b) anyone to provide information about you to BGC; (c) BGC to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) us to share those reports with others for legitimate business purposes related to your employment. BGC may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an applicant or employee with us.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

Personal Information: Please print the information requested below to identify yourself for BGC.

Printed name: Denise M Martinez

First | Middle (☐ none) | Last

Other names used: _____

Current and former addresses:

from Mo/Yr	to Mo/Yr	Street	City, State & Zip
2002	current	11844 Sherman St.	Northglenn, CO. 80233

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

5/14/1970 — Date of birth

523-15-0820 — Social security number

92-145-0307 CO. — Driver's license number & state

Denise Marcella Martinez — Name as it appears on license

Report Copy: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: ☐.

Denise Martinez — Signature

11/8/2016 — Date

EMERGENCY CONTACT INFORMATION

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

Employee Name: Denise Martinez

Address: 11844 Sherman Street, Northglenn, CO. 80233

Home Phone: (720) 569-8641

EMERGENCY CONTACTS Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: April Begler Relationship: Partner	Home Phone: Cell Phone: 720-435-2826 Work Phone:
Contact #2 Name: Mitch Joslin Relationship: Friend	Home Phone: Cell Phone: 720-270-3538 Work Phone:

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

_____

_____

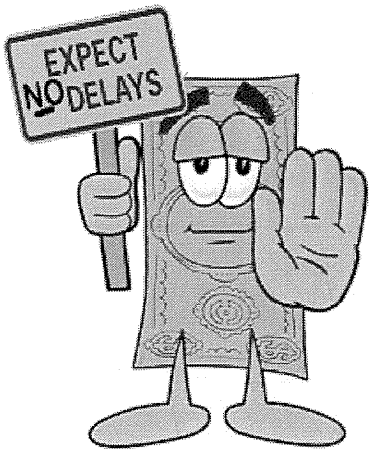
_____

_____

_____

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

RECEIVE YOUR PAY WITHOUT DELAY



In order for you to continue to receive your pay each week without delay we are encouraging all employees to use direct deposit or Global Cash Card. **It is becoming more and more difficult for employees to cash checks without fees or delay due to increased security at all banks. Also, if your check is lost or stolen you will have to wait 3 days for another check.**

GLOBAL CASH CARD

If you don't have a bank account, computer access or don't want to use direct deposit you can use **Global Cash Card** which works like a Visa.

- There are **NO FEES** for the card for your first transaction as a cash withdrawal at an ATM or if you use it like a credit card (not debit) to make individual signature purchases.
- **If you don't have access to a computer you can receive TEXT notifications for your pay check amount on pay day as well as what the current balance is. You can also receive low balance notifications set to the dollar amount that you determine on the attached form.**
- You may call Customer Service 24 hours a day, 7 days a week, 365 days a year at 888-220-4477 for balance inquiries or other questions. (Para Español, apriete dos)
- You can pay bills with the GCC (by phone/internet/in person). You can also set up your online account to make automatic payments.

Please complete the attached form and turn it in to your manager as soon as possible indicating whether you would like direct deposit or Global Cash Card. Please make sure you include an email address.

Fill Out This Form!

employer solutions staffing group
Leveraging Resources in a Changing Market

Direct Deposit/Payroll Debit Card Authorization

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

SECTION 1 BASIC INFORMATION

Employee Name	SSN# (last 4 digits)	Effective Date
Denise Martinez	0820	

SECTION 2 PAYROLL ELECTION

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

Note: Direct Deposit accounts may take up to 7 days to be activated.

SECTION 3 DIRECT DEPOSIT

ACCOUNT

☐ Update Bank Account

Bank Name:

Routing#

Account#

Account Type: ☐ Checking ☐ Savings ☐ Other _____

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.

Initial _____ Date _____

- 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 (GLOBAL CASH CARD)

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

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

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

First Name	M.I.	Last Name	Date of Birth

Street Address (PO BOX NOT ACCEPTABLE)	Social Security#

City	State	Zip	Cell Phone (mobile)

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

Payroll Debit Card Routing #	Payroll Debit Card Account #
073972181	

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: Denise Martinez Date: 11/8/2016

SECTION 5 AUTHORIZATION

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

***E-mail:** musicnote101 @ yahoo.com

this information will only be used to send your paystubs electronically

Employee's Signature: Denise Martinez Date: 11/8/2016

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

STATEMENT OF CONFIDENTIALITY

This agreement made this 8 day of November, 2016, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and _____ hereafter referred to as "employee".

WITNESSETH:

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of $10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

Denise Mash

Employee Signature

Employer Solutions Staffing Group LLC, Representative

Form **8850**
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

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

▶ See separate instructions.

OMB No. 1545-1500

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

Your name Denise Martinez Social security number ▶ 523-15-0820

Street address where you live 11844 Sherman Street

City or town, state, and ZIP code Northglenn, CO. 80233

County Adams Telephone number (720) 569-8641

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.

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 ▶ Denise Martinez **Date** 11/8/2016

Form A (rev. 08/12)

TAX CREDIT QUESTIONNAIRE

RETROTAX®
Specialists in Tax Credit Administration

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

Employee Name:	Street Address:	City/State:	Zip:
Denise Martinez	11844 Sherman Street	Northglenn, CO	80233

SS#:	Date of Birth:	Age:	Have you worked for this company before?	If yes, location:
523 15 -0820	5 / 14 / 1970	46	☐ Yes ☒ No	

Please complete all questions, and sign and date the form. Yes No

1. **Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?** (If yes, please provide information below.) ☐ ☒
   Name of the person receiving benefits: _____ Relationship to you: _____
   City: _____ County: _____ State: _____

2. **Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?** ☐ ☒
   (If yes, please provide information below.)
   Name of the person receiving benefits: _____ Relationship to you: _____
   City: _____ County: _____ State: _____

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.*

4. **Have you received any type of vocational rehabilitation services within the past two years?** ☐ ☒
   If yes, please indicate which type of agency you worked with and provide their location information below:
   ☐ Vocational Rehabilitation Agency ☐ Dept. of Veterans Affairs ☐ Employment Network (Ticket to Work Program)
   Name of Agency: _____ Phone #: _____
   City: _____ County: _____ State: _____
   **If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.*

5. **Are you a Veteran of the U.S. Military?** **If yes, please provide a copy of your DD-214 and letter of separation.* ☐ ☒
   (If yes, please provide information below. If no, please continue to question #6.)
   Dates of Service - From: ____/____/_____ To: ____/____/_____
   Branch of Service: _____
   Are you entitled to or are you receiving compensation for a service-connected disability? ☐ ☒
   Have you been unemployed at any time during the last 12 months? ☐ ☒
   If yes, dates of unemployment - From: ____/____/_____ To: ____/____/_____
   Did you receive unemployment compensation at any point during your unemployment? ☐ ☒

6. **Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?** ☐ ☒
   Conviction Date: ____/____/_____ Release Date: ____/____/_____
   Was this a ☐ Federal or ☐ State conviction? If State - County: _____ State: _____

Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe? ☐ ☒
**If you checked yes please provide a copy of your CDIB card.*

CA Residents: ☐ Are you the child of foster parents? ☐ Do you receive CalWorks? ☐ Workforce Investment Act?
☐ Are you a migrant or seasonal farm worker? ☐ Have you ever been convicted of a misdemeanor?

SC Residents: ☐ Do you receive Family Independence Benefits?

PLEASE READ, SIGN, AND DATE:

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: Denise Martinez **Date:** 11/8/2016

employer solutions staffing group
Leveraging Resources in a Changing Market

INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

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

RESPONSIBILITIES OF THE INJURED WORKER:

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

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

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

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

Follow all physical restrictions at home and at work.

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

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

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

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

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

Signed: Denise Mart

Printed Name: Denise Martinez

employer solutions staffing group

Leveraging Resources in a Changing Market

Important/Importante

LOST OR STOLEN PAYCHECKS

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

If your paycheck was **stolen**, you must first file a police report before we can 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): Denise Martinez

Signature/Firma: Denise Martinez

Employee Keeps This Form

Healthcare Notice of Exchange

As your employer, we are required to provide you with the following information under Section 1512 of the Affordable Care Act:

What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

*****The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area*****

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information:

Employer Name: Employer Solutions Staffing Group, LLC				Employer FEIN: 20-8084369	
Employer Address: 7301 Ohms Lane Suite 405 Edina, MN 55439				Phone Number for Health Benefits Team: 952-767-9519	
Insurance Plans Available:	**Who is Eligible?**	**Meets Minimum Value Standard?**	**Meets Minimum Essential Coverage?**	**When is it effective?**	**Will I be penalized if I only have this plan?**
Fixed Indemnity Plan	Everyone	No	No	Available immediately – offered upon hire	Yes
MEC Plan	Everyone	No	Yes	Available immediately – offered upon hire	No
Major Medical Plan	Full time employees after 120 hours are met in 30 days	Yes	Yes	Within 60 days of being determined eligible	No

For more information about ESSG's Insurance options, contact:

The Health Benefits Team

Employer Solutions Staffing Group

952-767-9519 | health@employersolutionsgroup.com

employer solutions staffing group
Leveraging Resources in a Changing Market

Notification of Colorado Law Requirement – Unemployment Acknowledgement

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

It is 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 once an assignment ends. I also acknowledge that I have received a separate copy of this form.
DM (Initial)

Denise Martinez — 11/8/2016
Employee Signature: Date:

Denise Martinez
Employee (please print your name here)

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

DRUG AND ALCOHOL TESTING POLICY

I. PURPOSE

Alcohol and drug abuse adversely affects job performance, the kind of work an employee performs and an employee's opportunities for successful employment. It is the intent of this document to provide employees with ESSG's [hereafter "the Company"] policy regarding the use of drugs and alcohol while at work. The Company does not intend to intrude into the private lives of its employees, but strongly believes that a drug-free workplace is in the best interest of employees and non-employees alike.

II. SCOPE

This policy applies to all applicants for employment and to all employees including contract or temporary employees. The policy is applicable at Company facilities or whenever Company employees are performing company business.

III. DISCLAIMER

Employment at the Company is at-will. This policy is not a unilateral employment contract and should not be interpreted as creating a unilateral employment contract.

IV. PROHIBITIONS

A. No employee shall report to work under the influence of alcohol, any controlled substances, or any other drugs or medications that may affect the employee's alertness, coordination, reaction, response, judgment, decision-making, or safety.

B. No employee shall operate, use, or drive any equipment, machinery, or vehicle of the Company or any client of Company while under the influence of alcohol, any controlled substances, or any other drugs or medications that may adversely affect the employee's ability to operate such equipment, machinery, or vehicle. Employees are under an affirmative duty to immediately notify their supervisor if they are not in an appropriate mental or physical condition to operate, use, or drive any equipment machinery, or vehicle or otherwise safely perform their job duties.

C. No employee shall unlawfully manufacture, distribute, dispense, possess, transfer, or use a controlled substance in the workplace or wherever the Company's work is being performed.

D. Engaging in off-duty sale, purchase, transfer, use or possession of illegal drugs or controlled substances may have a negative effect on an employee's ability to perform his/her work for the Company. In such circumstances, the employee is subject to discipline.

E. When an employee is taking medically authorized drugs or other substances that may alter job performance, the employee is under an affirmative duty to notify their supervisor of the temporary inability to perform his or her job duties.

F. The Company shall notify the appropriate law enforcement agency, licensing boards, and other relevant authorities when it has reasonable suspicion to believe that an employee may have illegal drugs in his or her possession at work or on company premises.

G. Employees shall not consume alcoholic beverages during lunch periods, dinner periods, or breaks when returning immediately thereafter to perform work on behalf of the Company. In situations where the employee conducts the Company's business after the intake of alcohol, the employee shall be subject to discipline up to and including discharge.

V. ALCOHOL AND DRUG TESTING

As part of the Company's commitment to an alcohol and drug-free workplace, the Company reserves the right to require that applicants and employees submit to drug or alcohol testing in accordance with the provisions of applicable law. This policy represents the notice required under applicable law and a copy will be provided to all applicants and employees who are requested to undergo testing. In the event of any conflict between this policy and applicable law in affect at the time of the test, the law will control.

A. Who May be Subject to Testing.

1. Job Applicants. The Company may require that all applicants for a particular position be tested for drugs or alcohol after receiving a conditional offer of employment. If the applicant tests positive for drugs or alcohol, the conditional offer may be withdrawn.

2. Routine Physical Examination Testing. The Company may require employees to undergo a drug or alcohol test once a year as part of a routine physical examination. Affected employees will be given two weeks written notice that they will be tested for drugs or alcohol as part of a routine physical.

3. Random Testing. The Company may require employees in safety-sensitive positions to undergo testing on a random selection basis. Once the random selection has been made, the Company will not waive the selection of any employees identified through the random process.

4. Reasonable Suspicion Testing. The Company may require an employee to undergo drug or alcohol testing if the Company reasonably suspects that the employee:

   a. is under the influence of drugs or alcohol;

   b. has violated the Company's written work rules prohibiting drug and alcohol use;

   c. has sustained or caused another employee to sustain personal injury; or

   d. has caused a work-related accident or was operating or helping to operate machinery, equipment or vehicles involved in a work-related accident.

5. Treatment Program Testing. The Company may require an employee who has been referred for chemical dependency treatment or evaluation or is participating in a treatment program under an employee benefit plan to undergo drug or alcohol testing on a random basis and without advance notice during the evaluation or treatment period and for up to two years following the completion of any treatment program.

B. Conducting the Testing.

1. Consent. All employees required to undergo testing will be required to complete and sign the employee consent form attached as Appendix A.

2. Refusal to Participate. An employee or job applicant has the right to refuse testing. However, a refusal of testing will be treated as a failure to comply with Company policy and may result in withdrawal of a job offer or disciplinary action up to and including termination of employment.

3. The Laboratory. The Company will use a laboratory certified by the National Institute on Drug Abuse (NIDA) or its successor, the College of American Pathologists (CAP), or the New York State Department of Health or other licensing body recognized by applicable law to perform all drug and alcohol tests.

4. Test Results.

The laboratory will conduct both an initial test and a confirmatory test if the initial test is positive. A negative result on either the initial or confirmatory test will be deemed a negative test result (i.e. the employee passed the test). A positive result on both the initial and confirmatory test will be deemed a positive test result (i.e. the employee failed the test.)

a. Negative Test Result. An employee or applicant who tests negative for drugs or alcohol will be given written notice that they passed the test within three working days of the Company receiving the test results from the testing laboratory.

b. Positive Test Result. An employee or applicant who tests positive for drugs or alcohol will be given written notice that they have failed the test within three working days of the Company receiving the test results from the testing laboratory. The employee or applicant will then be given the opportunity to provide any information to explain the positive result, including any over-the-counter or prescription medications the employee or applicant may have taken. An employee or applicant who wishes to submit any explanatory information must do so within three working days after being notified of the positive test result.

An employee or applicant who has a positive test result may also request a retest of the original sample by the same or different certified laboratory at his or her own expense. An employee or applicant who wishes to conduct a retest must notify the Company in writing of their intention to conduct such a retest within five working days after being notified of the positive test result. If the results of the retest are negative, the test will be considered a negative test result.

C. Right to Test Result. An employee or job applicant has the right to request and receive from the Company a copy of the test result report on any drug or alcohol test.

C. Costs. All costs related to alcohol and drug testing will be paid by the Company, with the exception of any retests requested by the employee or applicant following a positive test result.

D. Disciplinary Action in Response to a Positive Test Result.

1. Interim Discipline and Action: The Company reserves the right to temporarily suspend an employee or transfer the employee to another position at the same rate of pay pending the outcome of any drug or alcohol test. An employee who is suspended without pay will be reinstated with back pay if the test or any requested retest is negative.

2. Applicants. The Company reserves the right to withdraw the conditional job offer of any job applicant with a positive test result, without the opportunity to complete evaluation or treatment.

3. Employees - First Positive Test Result - Termination: The Company will not discharge an employee for the first positive test result. Instead the employee will be given the opportunity to participate in an appropriate drug or alcohol counseling or rehabilitation program as determined by a certified chemical use counselor or physician trained in the diagnosis and treatment of chemical dependency chosen by the Company. The employee will be responsible for paying all costs associated with any evaluation and subsequent treatment themselves or pursuant to coverage under an employee benefit plan. An employee who refuses or fails to participate in, cooperate with, or complete the evaluation or recommended treatment may be terminated. An employee who successfully completes treatment may be subject to random follow-up testing for a period of up to two years in accordance with section V.A.5. of this policy.

4. Employees - First Positive Test Result—Discipline: The Company reserves the right to take any other disciplinary action short of discharge it deems warranted following a first positive test result.

5. Employees-Subsequent Positive Test Result: An employee who has more than one positive test result may be terminated immediately following any second or subsequent positive test result without referral to or the opportunity to complete additional chemical dependency counseling or rehabilitation.

E. Privacy of Test Results.

1. Test results and other information acquired as a result of the testing program are private and confidential information and will not be disclosed by the Company or the testing laboratory to another employee or to third party individuals, government agencies, or private organizations without written consent of the employee or applicant being tested.

2. Evidence of a positive test result, however, may be used in an arbitration proceeding pursuant to a collective bargaining agreement, an administrative hearing, or a judicial proceeding, provided the information is relevant to the hearing or proceeding. Such evidence may also be disclosed to any federal agency or other unit of the United States government as required under federal law, regulation, or order. Evidence of a positive test result may also be disclosed to a substance abuse treatment facility for the purpose of evaluation or treatment.

3. The Company will provide an employee with access to information in the employee's file relating to positive test result reports and other information acquired in the testing process as well as conclusions drawn from or actions taken based upon such information.

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.

Denise Martel

Individual's Name

11/8/2016

Date

Temporary Assignment Guidelines for Allegro Coffee

Name: Denise Martinez Contact Phone: 720-569-8641

Emergency Contact & Phone: April Begler 720-435-2826

LOCATION:

Allegro Coffee Company, 12799 Claude Court, Thornton, CO 80241

CONTACTS:

Corporate Management Group: (303)920-1425 Allegro Coffee:

- Department: Tea Production (Jude Martinez 303-920-5472)
- Department: Spice Production (Rachel Power 303-920-5541)
- Department: Coffee Production (Trent Lukasiewicz 303-920-5475) (Brian Martinez 303-525-9232)
- Department: Shipping (Williams 303-920-5457)
- Department: Roasting (Joe DelaTerre 303-920-5495)
- Human Resources: Jessica Myers (303) 920-5400

Specific Notes on Assignment:

- Labeling, packing boxes, assistance in the production line. (Production positions)
- Pick orders for outgoing shipments, stocking, cleaning, other duties assigned by the team leader. (Shipping)
- Assisting with loading of green coffee beans, inventory, paperwork (Roasting)

GUIDELINES:

- You are a temporary employee of Corporate Management Group (CMG) who arranged for this assignment. All questions regarding your employment or paycheck should be directed towards your agency.
- Allegro Coffee places great importance on attendance, timeliness and performance. You may be released from your assignment at any time for those reasons.
- In the event of tardiness or absence, it is necessary that you contact CMG and your assigned team leader at least ONE HOUR prior to your scheduled start time.
- In case of an accident that results in an injury you must immediately notify your assigned team leader and your Agency.
- Allegro Coffee does not tolerate any kind of threatening or unprofessional behavior. Acts of this nature will be dealt with accordingly.

PERSONAL PROPERTY:

We are not responsible for personal property that is lost, damaged, stolen or destroyed. We ask that you not bring any valuables or large amounts of cash to work. Purses and wallets should be stored in a secure place at all times. Please see your team leader contact above if you are in need of a secure location for your valuables.

BREAKS & LUNCHES:

In order for all of us to remain productive, we all need time to rejuvenate:

- If you work at least a 4-6 hour shift, you will receive one paid 15-minute break.
- If you work at least 8-10 hour shift, you will receive two paid 15-minute breaks and one unpaid 30 minute lunch break.

Your assigned team leader will give you your assigned break and meal periods.

CELL PHONES:

Use of cell phones are prohibited in the warehouse except those authorized in order to conduct business.

SAFETY, QUALITY, QUANTITY:

- Be aware of your environment!
  - Forklifts
  - People carrying boxes that may not see you.
  - Packaging machines with gears that could harm you or your clothing if caught.
- Exhibit good housekeeping practices
  - Continue to clean up after self to keep debris from floor and potentially causing accident
- Use proper lifting techniques! (see below)
- Do things right the first time!
  - Quality is as important as speed. Listen carefully to instructions, ask questions, and focus on your task.

SAFE FOOD PRACTICES, APPAREL AND HYGIENE REOUIREMENTS:

Personal hygiene is an integral part of our Food Safety program. All team members/temporary employees who handle food in some fashion need to be aware of your personal hygiene in order to prevent food contamination or food borne illness.

Eating — No food is allowed in the Plant Operations area. Only eat in designated areas (i.e. offices, retail café, break room) Never eat while preparing food, this includes chewing gum.

Drinking — Water and disposable cups are available to Production and Shipping Team Members. No other beverages are allowed in the Plant Operations.

Smoking — This is a Non-smoking facility. Smoking is permitted in designated areas outside of the building. No other tobacco products are allowed in the Plant Operations.

Hair — Hairnets must be worn in the Plant Operations area. Beard covers are required for beards over 1/8 inch in length.

Personal Hygiene — Wash hands thoroughly after using the restroom, touching face or hair, coughing, sneezing, using a tissue, eating or smoking, etc. Hands must be washed before returning from breaks.

Jewelry — Team Members in Plant Operations should not wear jewelry. Medical Alert jewelry and plain wedding bands are permissible.

Clothing — Team Members should always wear clean outerwear. Shirts should not have any buttons or snaps that could potentially fall into product. Clothes that are baggy, torn, or ripped are not permitted. Shorts must be at mid-thigh and hemmed.

Illness — Team Members should not work with food if they are ill and should report any other Team Member who is complaining of illness. Be sure to report if you have any of the following symptoms: diarrhea, vomiting, fever, jaundice or sore throat with fever.

Injury — Do not work with food if you have infected cuts, abrasions, boils or any other condition that causes flaking of the skin (i.e. eczema, rash, etc.) on hands unless the affected area is bandaged and covered with a glove.

Other things to consider — Team Members in Plan Operations are not wear false nails or nail polish. If they do, gloves must be worn so as not to affect the product or risk a chip or nail to contaminate the product. Perfumes and other strong odors can affect the product and are not permitted.

SAFE LIFTING PRACTICES:

Back injuries account for 20% of all work place injuries, 40% of lost workdays. 80% of these injuries are to the lower back and 75% occur while lifting. By practicing safe lifting techniques at home and on the job you can lower your risk of having an injury that may keep you from working and even caring for your home and family.

Tips to avoid back injury:

- Stretch and exercise on a regular basis
- Plan your lift, if it's too big or awkward, get help
- If using a cart or a dolly, push - don't pull.
- Lift with your legs
- Keep the load close
- Keep your head up and keep the natural curve of your spine
- Keep your shoulders over your hips when setting the load down
- Avoid over-reaching and twisting

ACKNOWLEGEMENT:

I acknowledge that I have received and understand the information provided in the Temporary Assignment Guidelines for Allegro Coffee Company.

Denise Martinez 11/8/2016

Temporary Employee Signature | Printed Name | Date