



Leveraging Resources in a Changing Market

7301 Chino Lane, Suite 405  
Edina, MN 55438  
Tel: 952.835.1288 • Fax: 952.873.1255  
www.espsolutions.com

## New Hire Application

Personal Data—PLEASE PRINT LEGIBLY IN INK

Last Name DINN First Name ERIC Middle Initial \_\_\_\_\_  
 Street Address 61 DEQUAYE Apt/Site OS  
 City/State/Zip BROOKLYN NY 12226  
 Phone Number 315-837-7374 Email Address \_\_\_\_\_  
 Staffing Agency/Recruitment Partner \_\_\_\_\_

All offices 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, schools as indicated in this application regarding my previous roles, education, performance, compensation and eligibility for rehire.  
 I understand that a comprehensive background check may be conducted to determine my eligibility for this or other clients of ESSG. This may include but not limited to, investigations of criminal and/or conviction records, driving records under a flag system set up required by clients, government regulations or by ESSG policies.  
 I request ESSG and other persons or entities from any clients 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.

Eric Dinm Eric Dinm Applicant's Signature May 27 2015 Date

A copy of this form (Form 7) will be considered the same as an original signature. Email will ONLY be used for employment correspondence.

For ESSG Office Use Only			
DOB	NIW	I-9	ESB
Emergency Contact Info	Background Review Form	Background Results	Unemployment Letter (if applicable)
DOB	ROP	Work Site Loc.	VIC Code

For ESSG Client Use

ESSG-CMCL-SIG-Notation  
Rev 11/2011





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

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 age, race, sex, color, religion, or national origin they will not hire or accept for employment.

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

Last Name (Family Name)		First Name (Given Name)		Other Names Used (if any)	
DUNN		EPO			
Address (Street Number and Street)		City or Town		State	
141 Ocean Ave		CS		PAOKY	
Date of Birth (mm/dd/yyyy)		U.S. Social Security Number (9-Digit Number)		Country of Birth	
07/02/69		[REDACTED]		NY	
Date of Expiration (mm/dd/yyyy)		Employer's Date		Employee Number	
		3/1-3/7-2014			

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

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

- A citizen of the United States
- A national natural of the United States. (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number)
- An alien authorized to work until expiration date: (applicable, regardless of expiration date) \_\_\_\_\_ . Some aliens may not have their date.

For dates authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number.

OR  
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:

Country of Issuance: \_\_\_\_\_

Same as on your valid NEXUS or the Foreign Passport Number and Country of Issuance fields. (See instructions)

Signature of Employee: [Signature] Date (mm/dd/yyyy): 3/27/15

**Preparer and/or Employer 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 Employer: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

Last Name (Family Name) Title (Name (Given Name))

Address (Street Number and Street) City or Town State ZIP Code

Employer Completes Next Page

Form I-9 (3/08) 3 N

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

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title: <u>US Passport</u>		Document Title:		Document Title:
Issuing Authority: <u>US Department of State</u>		Issuing Authority:		Issuing Authority:
Document Number: <u>439689797</u>		Document Number:		Document Number:
Expiration Date (if any)(mm/dd/yyyy): <u>04/23/2018</u>		Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy):
Document Title:		<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p><b>3-D Barcode</b> Do Not Write in This Space</p> </div>		
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

### 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): 05/27/2015 (See instructions for exemptions.)

Signature of Employer or Authorized Representative <u>Caitlin Scholl</u>		Date (mm/dd/yyyy) <u>05/27/2015</u>	Title of Employer or Authorized Representative <u>Administrative Assistant</u>	
Last Name (Family Name) <u>Scholl</u>		First Name (Given Name) <u>Caitlin</u>	Employer's Business or Organization Name <u>Employer Solutions Staffing Group, LLC</u>	
Employer's Business or Organization Address (Street Number and Name) <u>7301 Ohms Lane Suite 405</u>			City or Town <u>Edina</u>	State <u>MN</u>
			Zip Code <u>55439</u>	

### 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:





EMERGENCY CONTACT INFORMATION

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

Employee Name: ERIC DUMY  
Address: 601 Ocean Ave, Apt C5  
Home Phone: 347-837-7314

EMERGENCY CONTACTS		Please list two people (in priority order) who could be contacted in case of an emergency.	
Contact #1	Name: <u>KAREN EBERNS</u>	Home Phone:	
	Relationship: <u>Girlfriend</u>	Call Phone: <u>919-448-631-591-4832</u>	
Contact #2	Name: <u>Cheryl Dumy</u>	Home Phone: <u>417-685-6733</u>	
	Relationship: <u>MOTHER</u>	Call Phone: <u>603-837-4832</u>	
		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.

**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: Steve Hill SSN: Last four: 8347 Employee ID: 512715

**SECTION 2: PAYROLL DEBIT CARD**

Direct Deposit (Sections 3 and 4)  Payroll Debit Card (This Section)

**SECTION 3: DIRECT DEPOSIT**

A  Direct Bank Account  
 B Bank Name: Bank of America  
 C Routing: 031003992  
 D Account: 4830126138336  
 E Account Type:  Checking  Savings  Other  
 I understand and acknowledge that if I do not provide a valid check with direct deposit to my bank, I am responsible for any delay in payroll or extra costs incurred if the account number that I provide is incorrect.  
 Initial: SH Date: 5/27/15

\* To help us avoid making a wire, please attach a copy of a voided check. A deposit slip will not work!  
 If you change banks, or not two years will bank account until your direct deposit has started in the new bank, which may take 2 pay periods.

**SECTION 4: PAYROLL DEBIT CARD (GLOBAL CARD)**

Federal law requires all financial institutions to identify, verify, and record information that identifies each person who opens an account. In order to open 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, ESSS will provide the necessary information and issue you a Payroll Debit Card for your production. The financial institution may ask you to provide more additional identification information so they can ensure that the routing and account number ESSS does not have access to any information regarding your Payroll Debit Card account. If you are requesting the Payroll Debit Card, you will receive your new Payroll Debit Card, and a booklet containing all of the terms and conditions. You will then open, acknowledging that you received the Payroll Debit Card and print Year Term of Debit Card will be released on each payday you receive wages.

**CARDHOLDER INFORMATION (ESSS you must your Payroll Debit Card to be issued)**

First Name: SH Last Name: \_\_\_\_\_  
 Street Address: 2000 W. 1st Street City: \_\_\_\_\_ State: TX ZIP: \_\_\_\_\_  
 Day Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**DEBIT CARD PAYROLL DEBIT CARD** to be completed when you get the new Payroll Debit Card.  
 Payroll Debit Card Routing #: \_\_\_\_\_  
 Payroll Debit Card Account #: \_\_\_\_\_

If you are requesting the Payroll Debit Card, you will receive your new Payroll Debit Card, and a booklet containing all of the terms and conditions. You will then open, acknowledging that you received the Payroll Debit Card and print Year Term of Debit Card will be released on each payday you receive wages.

**SECTION 5: AUTHORIZATION**  
 I authorize ESSS to directly deposit my periodic wages to the account/line of payment, and/or request the withdrawal of my wages after required withholdings for authorized deductions, and/or my recovery to be deposited to the card to salary. If recovery, debit entries, and adjustments are credited, entries made in error to my account.  
**Consent is required for pay info information.**

Employee's Signature: Steve Hill Date: 5/27/15  
 Employee's Signature: Steve Hill Date: 5/27/15  
 Email: Steve.Hill@esss.com



**STATEMENT OF CONFIDENTIALITY**

This agreement made this 27 day of May, 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and XXXXXXXXXX hereinafter 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

Department of the Treasury  
Internal Revenue Service  
Job applicant fill in the lines below and check any boxes that apply. Complete only this side.  
See separate instructions.  
Your name: Eric Dwyer Social Security number: 101568347  
Street address where you live: 11000 N. MEADOWS  
City or town, state, and ZIP code: BUNN, N. C. 27026  
Country: KINGS Telephone number: 347-831-7374  
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 (SSA) 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 6 months during the past 18 months.
  - I am a member of a family that has received Supplemental Nutrition Assistance Program (SNAP) benefits for any 6 months during the past 18 months.
  - I am a member of a family that has received Supplemental Security Income (SSI) for any 6 months during the past 18 months.
  - I am a member of a family that has received assistance from the Department of Veterans Affairs (VA) for any 6 months during the past 18 months.
  - 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 for any 6 months during the past 6 months, or
    - b. Received SNAP benefits for any 6 months during the past 6 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 awarded 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 five (5) months, or
  - Received TANF payments for at least five (5) months 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 these payments could be made.

Signature - All Applicants Must Sign  
Under penalty of perjury, I declare that I gave the above information to the best of my knowledge and belief, and I declare under penalty of perjury that I gave the above information to the best of my knowledge and belief.

Job applicant's signature: Eric Dwyer Date: 6/17/15  
Form 8830 (Rev. 09/11)



EMPLOYER SECTION:

ESG Client Name & State:

ESG FEIN#:

Position:

Starting Wage: \$

EMPLOYEE SECTION:

Employee Name <u>BRIE DUNN</u>	Street Address <u>611 OCEAN AVE, APT 5</u>	City/State <u>BROOKLYN, NY</u>	Zip <u>11226</u>
SSN: <u>101-56-8347</u>	Date of Birth <u>7/22/69</u>	Age <u>45</u>	Have you worked for this company before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		If yes, location:	

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 benefit: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 18 months?

Name of the person receiving benefits: SARIC DUNN Relationship to you: \_\_\_\_\_  
City: BROOKLYN, NY County: KINGS State: NY

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 yes, please provide a copy of your SSI documentation.)

Name of the person receiving benefits: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

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 (Tieker to Work Program)  
Name of Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

5. Are you a Veteran of the U.S. Military? (If yes, please provide a copy of your DD-14 and date of separation. If yes, please provide the information below. If no, please continue to question #6.)

Branch of Service: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
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? \_\_\_\_\_

1) Yes  2) No  3) Yes  4) No

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: \_\_\_\_\_

1) Yes  2) No  3) Yes  4) No

Additional Tax Credits

IEE (Native American): Are you or your spouse a member of a Native American Tribe?  Yes  No

CA Residents:  Do you receive CalWORKs?  Workforce Investment Act?  Yes  No

SR Residents:  Do you receive Family Independence Benefits?  Yes  No

PLEASE READ, SIGN, AND DATE:

I, the undersigned, declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize any agency, organization, or individual to supply such verification or information that may be needed to determine my eligibility for my employer's employee representative (classroom) consultation fee, the knowledge, or the Department of Labor.

New Employee Signature: [Signature] Date: 5/27/15

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.

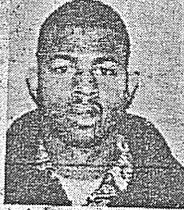
I have read my responsibilities and agree to abide by these guidelines.

Signed: Eric Durn

Printed Name: Eric Durn

NEW YORK STATE

*Andrew M. Cuomo*  
Commissioner of Motor Vehicles



*Eric Dunn*

DRIVER LICENSE

ID: 982 537 693 CLASS D

DUNN  
ERIC  
611 OCEAN AVE C5  
BROOKLYN NY 11226

DOB: 07-22-69  
SEX: M EYES: BR HT: 6-03

E: NONE  
R: NONE

ISSUED: 05-24-10 EXPIRES: 07-22-17 IL0450EG00

**SENSITIVE BUT UNCLASSIFIED**

**Department of Homeland Security**  
**E-Verify**

**Report Prepared: 05/29/2015**  
**Page: 1 of 1**

**Case Verification Number: 2015149120612CZ**

**Case Information:****Employee Information:**

Last Name:	Dunn	First Name:	Eric
Middle Initial:		Other Names Used:	
Social Security Number:	*** ** 8347	Date of Birth:	07/22/1969
Citizenship Status:	A citizen of the United States	Email Address:	

**Document Information:**

List A Document:	U.S. Passport or Passport Card		
Passport or Passport Card Number:	439689797	Document Expiration Date:	04/23/2018
Alien Number:		I-94 Number:	

**Additional Information:**

Hire Date:	05/27/2015	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CSCH4411	Submitted On:	05/29/2015

**Initial Case Result:**

Case Result: Employment Authorized

**Employee Referred to SSA:**

Referred By: Referred On:

**Case Result from SSA (after SSA Tentative Nonconfirmation):**

Case Result: Response Date:

**Resubmitted to SSA (after Review and Update Employee Data):**

Last Name:		First Name:	
Middle Initial:		Other Names Used:	
Social Security Number:		Date of Birth:	
Resubmitted By:		Resubmitted On:	

**Case Result from SSA (after Resubmission):**

Case Result:

**Request Name Review:**

Comments:  
 Submitted By: Submitted On:

**Case Result from DHS (after DHS Verification in Process):**

Case Result: Response Date:

**Employee Referred to DHS:**

Referred By: Referred On:

**Case Result from DHS (after DHS Tentative Nonconfirmation):**

Case Result: Response Date:

**Photo Matching Results:**

Determination:

**Employee Referred to DHS (Additional):**

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Referred By: \_\_\_\_\_ Referred On: \_\_\_\_\_

**Case Result from DHS (after Additional DHS Tentative Nonconfirmation):**

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Case Result: \_\_\_\_\_ Response Date: \_\_\_\_\_

**Case Closure:**

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Closure Statement: \_\_\_\_\_  
Closed By: \_\_\_\_\_ Closed On: \_\_\_\_\_

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**SENSITIVE BUT UNCLASSIFIED**