



## New Hire Application

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

Last Name Mattaldi First Name Hamilton Middle Initial NA  
 Street Address 1308 69th Ave. N. Apt/Ste 308  
 City/State/Zip BROOKLYN CENTER MN. 55430  
 Phone Number (612) 402-7952 Email Address hmattaldi@yahoo.com  
 Staffing Agency/Recruitment Partner CGM 10 Panell

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 rehiring.

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.

Hamilton Mattaldi Name (Print or type) Hamattaldi Applicant's Signature 6-30-15 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 _____	8860 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (If applicable) _____	ESC Application _____
For ESSG Client Use				
DOH _____	ROP _____	Work Site Loc. _____	WG Code _____	

# Employee's Withholding Allowance Certificate

2015

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

1 Your first name and middle initial <i>Hamilton</i>		Last name <i>Mattalodi</i>		2 Your social security number <i>477-43-6651</i>	
Home address (number and street or rural route) <i>1308 69th Ave. N. #308</i>				3 <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code <i>Brooklyn Center MN. 55430</i>				4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5	<i>2</i>
6 Additional amount, if any, you want withheld from each paycheck				6	\$
7 I claim exemption from withholding for 2015, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, and • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> 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.) ▶ <i>Hamattalodi</i>				Date ▶ <i>6-30-15</i>	
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)



# 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) <u>Mattaldi</u>		First Name (Given Name) <u>Hamilton</u>		Middle Initial	Other Names Used (if any) <u>NA</u>	
Address (Street Number and Name) <u>1308 69th Ave. N.</u>		Apt. Number <u>308</u>	City or Town <u>Brooklyn Center</u>		State <u>MN.</u>	Zip Code <u>55430</u>
Date of Birth (mm/dd/yyyy) <u>05-04-1984</u>	U.S. Social Security Number <u>477-43-6651</u>	E-mail Address <u>hmattaldi@yahoo.com</u>			Telephone Number <u>(612) 402-9952</u>	

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

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

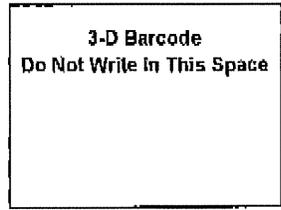
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): A# 094-638-528
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_ . Some aliens may write "N/A" in this field. (See instructions)

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

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

**OR**

2. Form I-94 Admission Number: \_\_\_\_\_



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

Foreign Passport Number: \_\_\_\_\_

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

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

Signature of Employee: <u>H. Mattaldi</u>	Date (mm/dd/yyyy): <u>6-30-15</u>
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**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



Employer Completes Next 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: Mattaldi, Hamilton

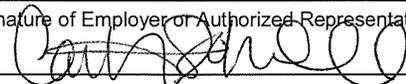
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: <u>Driver's license</u>		Document Title: <u>Social Security Card</u>
Issuing Authority:		Issuing Authority: <u>Minnesota</u>		Issuing Authority: <u>Social Security Administration</u>
Document Number:		Document Number: <u>F926095254017</u>		Document Number: <u>477-43-66051</u>
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy): <u>05/04/2018</u>		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): 06/30/2015 (See instructions for exemptions.)

Signature of Employer or Authorized Representative 		Date (mm/dd/yyyy) <u>06/30/2015</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: Hamilton Mattaladi  
 Address: 1308 69th Ave. N. #308 Brooklyn Center MN-55430  
 Home Phone: (763) 208-6207

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
<p style="text-align: center;"><b>Contact #1</b></p> <p>Name: <u>Yatta Davies</u></p> <p>Relationship: <u>wife</u></p>	<p>Home Phone: <u>(763) 208-6207</u></p> <p>Cell Phone: <u>(612) 552-0768</u></p> <p>Work Phone: <u>N/A</u></p>
<p style="text-align: center;"><b>Contact #2</b></p> <p>Name: <u>Joanna Tamba</u></p> <p>Relationship: <u>step mom</u></p>	<p>Home Phone: <u>NA</u></p> <p>Cell Phone: <u>(612) 703-2604</u></p> <p>Work Phone: <u>NA</u></p>

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

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**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 Hamilton Mattalci SSN# (last 4 digits) 6651 Effective Date 6-30-15

**SECTION 2 PAYROLL ELECTION**

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

**SECTION 3 DIRECT DEPOSIT**

Update Bank Account

Bank Name: Wings Financial GRP  
 Routing# 296076152  
 Account# 3919683  
 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 HM Date 6-30-15

- 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, BSSG 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 # 073972181 Payroll Debit Card Account # \_\_\_\_\_

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

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

**SECTION 5 AUTHORIZATION**

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

\*E-mail: hmattalci @ yahoo.com  
 this information will only be used to send your paystubs electronically

Employee's Signature: hmattalci Date: 6-30-15



August 12, 2013

RE: Hamilton Mattaldi Direct Deposit into Saving's account

To Whom It May Concern:

Hamilton Mattaldi is a member of Wings Financial Credit Union. The following information is required to initiate a direct deposit or debit from his account:

Wings Financial Credit Union routing number: 296076152  
Account Number: 391968300

Sincerely,

A handwritten signature in cursive script that reads "Karen M Barrett".

Karen M Barrett  
Member Services



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## STATEMENT OF CONFIDENTIALITY

This agreement made this 6-30 day of 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Hamilton hereafter referred to as "employee".

### WITNESSETH:

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

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

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

\_\_\_\_\_  
Employer Solutions Staffing Group LLC, Representative

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

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

OMB No. 1545-1500

▶ See separate instructions.

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

Your name Hamilton Mattalodi Social security number ▶ 477-43-6651  
 Street address where you live 1308 67th Ave. N. # 308  
 City or town, state, and ZIP code Brooklyn Center MN. 55430  
 County Hennepin Telephone number (612) 402-9951  
 If you are under age 40, enter your date of birth (month, day, year) 05-04-1984

- 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 ▶ Hamilton Mattalodi  
For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Date 6-30-15  
Form **8850** (Rev. 1-2012)

Form A (rev. 08/12)

# TAX CREDIT QUESTIONNAIRE



### EMPLOYER SECTION:

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

### EMPLOYEE SECTION:

Employee Name: <i>Hamilton Mattaldi</i>	Street Address: <i>1308 69th AVE. N. #308</i>	City/State: <i>Brooklyn Center</i>	Zip: <i>55430</i>
SS#: <i>477-45-6651</i>	Date of Birth: <i>05/04/1984</i>	Age: <i>31</i>	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

- 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: \_\_\_\_\_  Yes  No
- 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: \_\_\_\_\_  Yes  No
- 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.  Yes  No
- 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.  Yes  No
- 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: \_\_\_\_\_  Yes  No  
Are you entitled to or are you receiving compensation for a service-connected disability?  Yes  No  
Have you been unemployed at any time during the last 12 months?  
If yes, dates of unemployment - From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_  Yes  No  
Did you receive unemployment compensation at any point during your unemployment?  Yes  No
- Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?  Yes  No  
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?  Yes  No  
\*If you checked yes 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: *Hamilton Mattaldi*

Date: *6-30-15*



## 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: Hamilton Mattaldi

Printed Name: Hamilton Mattaldi



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## Important/Importante

### LOST OR STOLEN PAYCHECKS

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

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

### CHEQUES DE PAGO PERDIDOS O ROBADOS

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

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

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Hamilton Mallalchi

Signature/Firma: Hamattalchi

Ordered

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

\_\_\_\_\_, or any of its subsidiaries may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" conducted by a consumer reporting agency which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history (State and Federal records), social security verification, address trace, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any report conducted by a consumer reporting agency. Please be advised NationSearch.com, LLC (NationSearch)—11184 Huron St. Suite 13; Northglenn, CO 80234; (800)-827-9550—will be the consumer reporting agency conducting the background investigation. The scope of this notice and authorization is all encompassing, however, allowing the Company to obtain from any outside organization all manners of consumer reporting now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any report conducted by a consumer reporting agency.

**ACKNOWLEDGEMENT AND AUTHORIZATION**

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, credit reporting agency, employer, to provide any and all background information requested by NationSearch.com, LLC—11184 Huron St. Suite 13; Northglenn, CO 80234 (800)-827-9550—another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

**Notice to California Applicants:** Notice to California Applicants: Under section 1736.22 of California Civil Code, you have the right to request from NationSearch, upon proper identification, the nature and substance of all information in files pertaining to you, including the sources of information, and recipients of any reports on you, which NationSearch has previously furnished within the two-year period preceding your request. You may view the file maintained on you by contacting NationSearch during normal business hours. You may also obtain a copy of this report(s) upon submitting proper identification. Upon making a written request, you may receive a summary of your report.

**New York applicants or employees only:** You have the right to inspect and receive a copy of any report conducted by a consumer reporting agency and requested by the Company by contacting the consumer reporting agency identified above directly.

**Notice to Maine Applicants:** Under Chapter 210 Section 1314 of Maine revised Statutes, you have the right, upon request, to be informed within 5 business days of such a request to whether or not a consumer report was requested. If such report was obtained, you may contact the consumer reporting agency, NationSearch, and request a copy of the report(s) compiled.

**Minnesota and Oklahoma applicants or employees only:** Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company

Last Name: Mattaldi		First Name: Hamilton		Middle Name:
Other Names Used:		SSN: 477_43_6651	Date of Birth: (For Employment Purposes Only) 05/04/1984	
Motor Vehicle Number & State of Issue: (Driver's License Number)		Current Address: 1308 69th Avenue N #308 Brooklyn center 55430		

Signature: Hamilton Mattaldi  
Hamilton Mattaldi (Jun 29, 2015)

Date: Jun 29, 2015

Please initial this box in affirmation that you have been advised of your rights as it pertains to this consumer report, and are aware of the consumer reporting agency conducting the background investigation:

# Background Authorization Form

Adobe Document Cloud Document  
History

June 29, 2015

Created:	June 26, 2015
By:	Caitlin Scholl (Caitlin@corpmgmtgroup.com)
Status:	SIGNED
Transaction ID:	XP81VZF63W5L4WI

## “Background Authorization Form” History



Document created by Caitlin Scholl (Caitlin@corpmgmtgroup.com)

June 26, 2015 - 10:52 AM MDT - IP address: 71.211.151.144



Document emailed to Hamilton Mattaldi (hmattaldi@yahoo.com) for signature

June 26, 2015 - 10:52 AM MDT



Document viewed by Hamilton Mattaldi (hmattaldi@yahoo.com)

June 26, 2015 - 11:01 AM MDT - IP address: 172.56.21.218



Document e-signed by Hamilton Mattaldi (hmattaldi@yahoo.com)

Signature Date: June 29, 2015 - 9:45 AM MDT - Time Source: server - IP address: 172.56.13.250



Signed document emailed to Hamilton Mattaldi (hmattaldi@yahoo.com) and Caitlin Scholl (Caitlin@corpmgmtgroup.com)

June 29, 2015 - 9:45 AM MDT

**SENSITIVE BUT UNCLASSIFIED**

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

**Report Prepared: 07/06/2015**  
**Page: 1 of 1**

**Case Verification Number: 2015187114601EU**

**Case Information:**

**Employee Information:**

Last Name:	Mattaldi	First Name:	Hamilton
Middle Initial:		Other Names Used:	
Social Security Number:	*** ** 6651	Date of Birth:	05/04/1984
Citizenship Status:	A lawful permanent resident	Email Address:	

**Document Information:**

List B Document:	Driver's license or ID card issued by a U.S. state or outlying possession	List C Document:	Social Security Card
Document Name:	Driver's license	Document State:	Minnesota
Driver's License or ID Card Number:		Document Expiration Date:	05/04/2018
Alien Number:	094638528	I-94 Number:	

**Additional Information:**

Hire Date:	07/06/2015	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CSCH4411	Submitted On:	07/06/2015

**Initial Case Result:**

Last Name (in DHS records):	MATTALDI	First Name (in DHS records):	HAMILTON
Case Result:	Employment Authorized		

**Employee Referred to SSA:**

Referred By:		Referred On:	
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**Case Result from SSA (after SSA Tentative Nonconfirmation):**

Case Result:		Response Date:	
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**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:	
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**Employee Referred to DHS:**

Referred By:		Referred On:	
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**Case Result from DHS (after DHS Tentative Nonconfirmation):**

Case Result:		Response Date:	
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**Photo Matching Results:**

Determination:

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

Referred By:

Referred On:

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

Case Result:

Response Date:

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**Case Closure:**

Closure Statement:

Closed By:

Closed On:

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**SENSITIVE BUT UNCLASSIFIED**