



7301 Ohms Lane Suite 405

Edina, MN 55439

Tel: 952.835.1288 • Fax: 952.835.1255

www.esgstaffingsolutions.com

# New Hire Application

Personal Data - PLEASE PRINT LEGIBLY IN INK

Last Name: Johnson  
 First Name: Luke  
 Middle Initial: I  
 Street Address: 725 26th Ave N  
 City/State/Zip: Sunb Cloud MN 56303  
 Phone Number: 763 301 9708  
 Email Address: \_\_\_\_\_ @ \_\_\_\_\_  
 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.

Name (Print or type): Luke Johnson  
 Applicant's Signature: [Signature]  
 Date: 12-13-14

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

DOH		NHW		1-8		8850		WA	
Emergency Contact Info		Background Release Form		Background Results		Unemployment Letter (if applicable)		ESC Application	
For ESSG Client Use									
DOH		ROP		Work Site Loc.		WIC Code		ESSG - CMC	

# Form W-4 (2014)

**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 to update it. Your exemption for 2014 expires February 17, 2015. 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 an exemption from withholding if your income exceeds \$1,000 and includes more than \$200 of unearned income (for example, interest and dividends).

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

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

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The 1040-ES, Estimated tax payments using Form W-4, 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 the 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 2014. See Pub. 505, especially if your earnings exceed \$130,000 (single) or \$100,000 (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/wk4](http://www.irs.gov/wk4).

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

- A** Enter "1" for yourself if no one else can claim you as a dependent.
- 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.
- 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.)
- D** Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.
- E** Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).
- 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.)
- 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 \$65,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children.
- If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child.
- 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.)
- 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.

## Employee's Withholding Allowance Certificate

OMB NO. 1545-0074  
2014

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: John  
 Last name: Johnson  
 Home address (number and street or rural route): 725 26th Ave N  
 City or town, state, and ZIP code: Smithfield MD 20688  
 2 Your social security number: 477-25-3064  
 3  Single  Married  Married, but withheld at higher Single rate  
 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. Smithfield MD 20688

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2): 1  
 6 Additional amount, if any, you want withheld from each paycheck: 0  
 7 Claim exemption from withholding for 2014, and I certify that I meet both of the following conditions for exemption:  
 • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and  
 • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.  
 If you meet both conditions, write "Exempt" here.  
 Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.  
 Employee's signature: John Johnson  
 (This form is not valid unless you sign it.)  
 8 Employer's name and address (Employer complete lines 8 and 9 only if sending to the IRS.)  
 9 Office code (optional)  
 10 Employer identification number (EIN): 12-15-11



Address (Street Number and Name)		City or Town	State	ZIP Code
Last Name (Family Name)		First Name (Given Name)		
Signature of Preparer or Translator:		Date (mm/dd/yyyy):		

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.

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

Signature of Employee:	Date (mm/dd/yyyy): 12-15-2011
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Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Country of Issuance:

Foreign Passport Number:

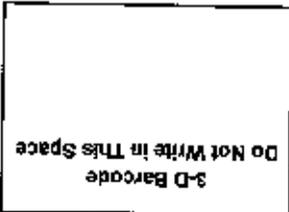
If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

2. Form I-94 Admission Number:

OR

1. Alien Registration Number/USCIS Number:

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

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

A noncitizen national of the United States (See instructions)

A citizen of the United States

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

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.

Date of Birth (mm/dd/yyyy): 12-01-1992		U.S. Social Security Number: HT7-25-31064	
Address (Street Number and Name): 725 26th Ave N		Apt Number:	City or Town: Saint Cloud MN
State: MN		Zip Code: 56303	Telephone Number: 763 301 4708
Last Name (Family Name): Johnson		First Name (Given Name): Mike	Middle Initial: J
Other Names Used (if any):			

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.

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

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

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

**Section 3: Verification and Rehire. (To be completed and signed by employer or authorized representative.)**

Last Name (Family Name)	First Name (Given Name)	Employer's Business or Organization Name
<i>Renzo Burns</i>	<i>Renzo</i>	<i>EMPLOYER SOLUTIONS STAFFING GROUP LLC</i>
Signature of Employer or Authorized Representative	Date (mm/dd/yyyy)	Title of Employer or Authorized Representative
<i>Renzo Burns</i>	<i>12-15-2014</i>	<i>On Site Rep.</i>
Employer's Business or Organization Address (Street Number and Name)	City or Town	State
<i>7301 OHMS LANE SUITE 405</i>	<i>EDINA</i>	<i>MN</i>
Zip Code	Zip Code	
<i>55439</i>	<i>55439</i>	

The employee's first day of employment (mm/dd/yyyy): *12-15-14* (See instructions for exemptions.)

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the employee is authorized to work in the United States.

**Certification**

Document Title:	Document Number:	Issuing Authority:	Expiration Date (if any) (mm/dd/yyyy):
<i>MN DL</i>	<i>E335015413011</i>	<i>State of MN</i>	<i>12-1-17</i>
Document Title:	Document Number:	Issuing Authority:	Expiration Date (if any) (mm/dd/yyyy):
<i>SS Card</i>	<i>477-25-3064</i>	<i>Dept of Health/Human Serv</i>	<i>12-1-17</i>

Identify and Employment Authorization OR List B AND List C Employment Authorization

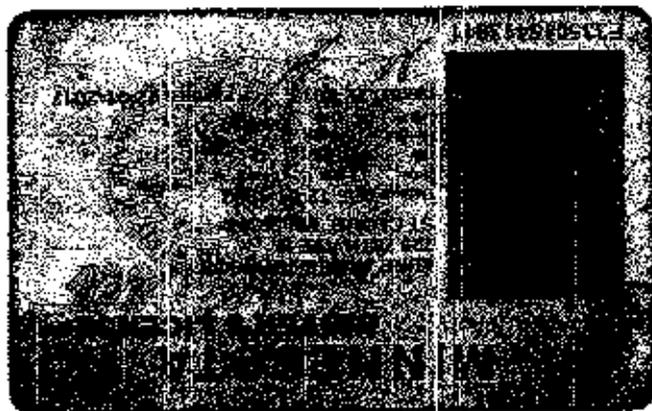
Employee Last Name, First Name and Middle Initial from Section 1: *Johnson, Luke J.*

**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.)

3-D Barcode  
Do Not Write in This Space





**Notification of Minnesota Law Requirement -  
Unemployment Acknowledgement**

According to Minnesota Statute section 268.095, subdivision 2, paragraph (d), an applicant who, within five calendar days after completion of a suitable job assignment from a staffing service, (1) fails without good cause to affirmatively request an additional suitable job assignment, (2) refuses without good cause an additional suitable job assignment offered, or (3) accepts employment with the client of the staffing service, is considered to have quit employment.

This paragraph applies only if, at the time of beginning of employment with the staffing service, the applicant signed and was provided a copy of a separate document written in clear and concise language that informed the applicant of this paragraph and that unemployment benefits may be affected.

It is your responsibility to contact ESSG (for instance, by calling 1-320-281-5617 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

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

Employee Signature: *[Signature]*  
Date: 12-25-14

Employee (please print your name here)  
*Mark Johnson*

**DISCLOSE AND AUTHORIZATION [IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]**

**DISCLOSE REGARDING BACKGROUND INVESTIGATION**

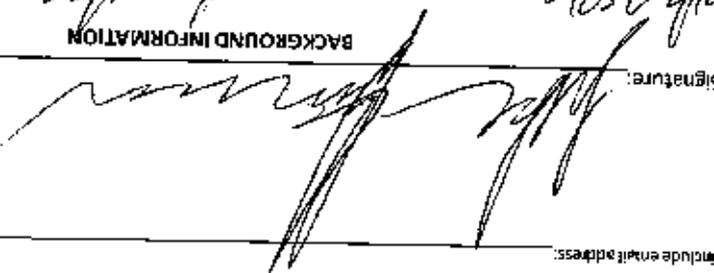
Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. This may be the subject of a "consumer report" and/or an "investigative consumer report" that may include information about your character, general reputation, personal characteristics, and/or mode of living, and that can involve personal interviews with sources, such as your neighbors, friends, or associates. These reports may contain information regarding your education or employment history, criminal history, credit history, validation, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been requested and advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel: 800-886-4777 or 952-941-9040. Fax: 800-886-0774 or 952-941-9041. ORANGE TREE EMPLOYMENT SCREENING'S website is at [www.orangetreescreening.com](http://www.orangetreescreening.com), or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing ESSG to obtain from any outside organization all manner of consumer reports and investigative consumer reports 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 investigative consumer report.

<p><b>New York and Maine applicants or employees only:</b> You have the right to inspect and receive a copy of any investigative consumer report requested by ESSG by contacting the consumer reporting agency identified above directly. You may also contact ESSG to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which ESSG shall provide within 5 days.</p>
<p><b>New York applicants or employees only:</b> Upon request, you will be informed whether or not a consumer report was requested by ESSG, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.</p>
<p><b>Oregon applicants or employees only:</b> Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that ESSG has not maintained secured records is available to you upon request.</p>
<p><b>Washington State applicants or employees only:</b> You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.</p>

**ACKNOWLEDGMENT 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 these documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by ESSG at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, company, or insurance company to furnish any and all background information requested by Orange Tree Employment Screening, 7275 Ohms Lane, Minneapolis, MN 55439. Tel: 800-886-4777 or 952-941-9040. ORANGE TREE EMPLOYMENT SCREENING'S website is at [www.orangetreescreening.com](http://www.orangetreescreening.com), 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.

**New York applicants or employees only:** By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law, **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 ESSG.  (Must include email address)

Signature: 

Date: 12-15-14

Last Name: Johnson  
 First: James  
 Middle: James

Other Names/Alia: 477 25 3064

Social Security #: E335015413011

Driver's License #: 725-264 Ave N

Present Address: Summit Blvd

City/State/Zip: Minnesota

Date of Birth (mm/dd/yyyy): 12 01 1992

State of Driver's License: Minnesota

Telephone # (Primary): 763 901 9708

\*This information will be used for background screening purposes only and will not be used as hiring criteria.

**EMERGENCY CONTACT INFORMATION**

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

Employee Name: Like James JOHNSON  
 Address: 125 26th ave N Saint Cloud 56303  
 Home Phone: 320 229 1133

Home Phone: 763 482 5133 Cell Phone: Work Phone:	Contact #1 Name: Connie Cichy Relationship: Grandmother
Home Phone: 763 482 5155 Cell Phone: Work Phone:	Contact #2 Name: Amanda Johnson Relationship: Sister

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

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

**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: Luke Johnson SSN# (last 4 digits): 477-25-3864 Effective Date: 12-15-14

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

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: [Signature] Date: 12-15-14

**SECTION 4 PAYROLL DEBIT CARD (G-DRAL CASI 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: Luke M.I.: J Last Name: Johnson Date of Birth: 12-01-92

Street Address (po box not acceptable): 725 26th Ave N Social Security#: \_\_\_\_\_

City: Saint Cloud State: MN Zip: 56303 Cell Phone (mobile): 763 301 9708

**GET TEXT ALERTS**, when your paycheck is deposited on your card!

Yes, sign me up for text alerts

My mobile service provider is: \_\_\_\_\_

**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 #: 4853400143686667

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: [Signature] Date: 12-15-14

**SECTION 5 AUTHORIZATION**

I authorize ESSG to directly deposit my periodic wages/compensation pay minus 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: \_\_\_\_\_

This information will only be used to send your paystubs electronically.

Employee's Signature: [Signature] Date: 12-15-14

**STATEMENT OF CONFIDENTIALITY**

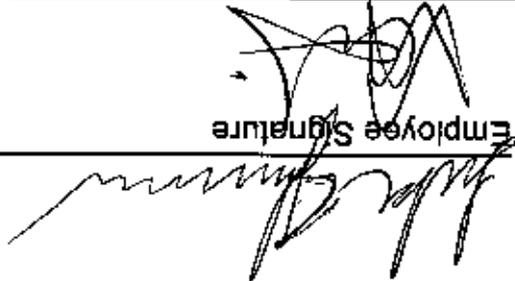
This agreement made this 15 day of December, 2014, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Mike Johnson hereafter referred to as "employee":

**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

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

OMB No. 1545-1500

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

Your name Luke Summers Johnson Street address where you live 725 22th Ave N  
 City or town, state, and ZIP code Smyth Cloud  
 County Stedman  
 Telephone number 763-301-9708  
 If you are under age 40, enter your date of birth (month, day, year) 12-01-92

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 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 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 *Luke Summers Johnson*

Date 12-15-14

**TAX CREDIT QUESTIONNAIRE**

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

**EMPLOYEE SECTION:**

Employee Name:	Street Address:	City/State:	Zip:
Luke Johnson	725 26th Ave N	Sault Ste Marie MI	50303
SSN:	Date of Birth:	Age:	Have you worked for this company before? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
477-25-3064	12/1/92	22	
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 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: Luke Johnson Relationship to you: MS  
 City: Sault Ste Marie 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.

Yes  No

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.)

Yes  No

Dates of Service - From: \_\_\_\_\_ To: \_\_\_\_\_  
 Branch of Service: \_\_\_\_\_

Are you entitled to or are you receiving compensation for a service-connected disability?  Yes  No

If yes, dates of unemployment - From: \_\_\_\_\_ To: \_\_\_\_\_  
 Did you receive unemployment compensation at any point during your unemployment?  Yes  No

6. 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**

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

\*If you checked yes please provide a copy of your CLIB card.

CA Residents:  Are you the child of foster parents?  Do you receive CalWorks?  Workforce Investment Act?

SC Residents:  Do you receive Family Independence Benefits?  Are you a migrant or seasonal farm worker?  Have you ever been convicted of a misdemeanor?

**PLEASE READ, SIGN, AND DATE:**

Under penalty of perjury, I declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize my agency, organization, or individuals to supply such verification of information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. (for Retros), or the Department of Labor.

New Employee Signature: [Signature] Date: 12-13-14

## INJURY MANAGEMENT PROGRAM

### Injured Worker's Responsibilities

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

### RESPONSIBILITIES OF THE INJURED WORKER:

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

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

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

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

Follow all physical restrictions at home and at work.

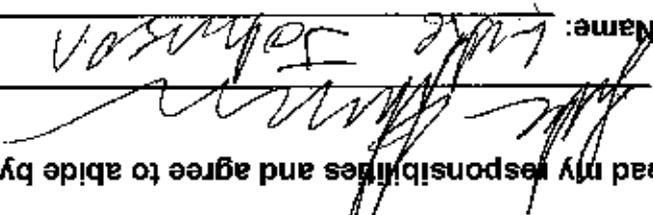
Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

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

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

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

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

Signed:   
Printed Name: Luke Johnson



# 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.

—ACREED/SE ACUERDA—

Name/Nombre (con letra de molde): Mike Johnson

Signature/Firma: [Handwritten Signature]

## 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](http://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

Employer Solutions Staffing Group does have an insurance plan that is offered to you upon hire. The Essential StaffCARE insurance is a fixed indemnity plan and is not a qualifying plan for the exchange. It does not meet the minimum value standard. If you elect to have this insurance *and only have* this insurance, you will be subject to a tax penalty beginning for year 2014.

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

The Health Benefits Team

Employer Solutions Staffing Group

952-767-9519

[health@employersolutionsgroup.com](mailto:health@employersolutionsgroup.com)

## ENROLLMENT FORM

FSC NAV+SAD P2M v15.0

### REQUIRED EMPLOYEE INFORMATION

**(Must Be Filled Out)**  
 Social Security Number: 477-25-2064  
 Date of Birth: 12/01/1992 Sex:  M  F  
 Name: Luke Johnson  
 Street Address: 125 25th Ave N  
 City/State: Saint Cloud MN 56303  
 Home Phone: 320-249-1633

Do you or any dependents have Medicare?  
 Yes  No If Yes:  
 Medicare Health Insurance Claim Number (HICN): \_\_\_\_\_  
 Medicare Effective Date: \_\_\_\_\_  
 Names of Covered Person(s):  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

### REQUIRED DEPENDENT INFORMATION

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

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

### BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.  
 NAME OF BENEFICIARY: \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_

Accidental Death & Dismemberment is part of the Term Life Benefit.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declaration of coverage.

Signature: [Handwritten Signature]  
 Date: 12/15/2014

### OPTION 1 FIXED INDEMNITY PLAN

You MUST enroll in the Indemnity Medical Insurance Plan before adding any additional Indemnity benefits, except Dental. Your coverage level for the Term Life will be identical to your medical plan selection.

**FIXED INDEMNITY MEDICAL**  
 \$20.91 Employee Only  
 \$42.44 Employee + 1  
 \$56.67 Employee + Family  
 NO to all Indemnity benefits.

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

### DENTAL

\$5.99 Employee Only  
 \$11.98 Employee + 1  
 \$19.77 Employee + Family  
 NO

### TERM LIFE

\$0.60 Employee Only  
 \$0.90 Employee + 1  
 \$1.80 Employee + Family  
 NO

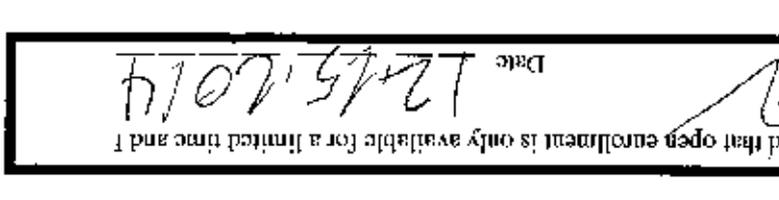
Short Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

### OPTION 2 MFC WELLNESS/PREVENTIVE PLAN

82193010-M-E-MP Monthly Rates

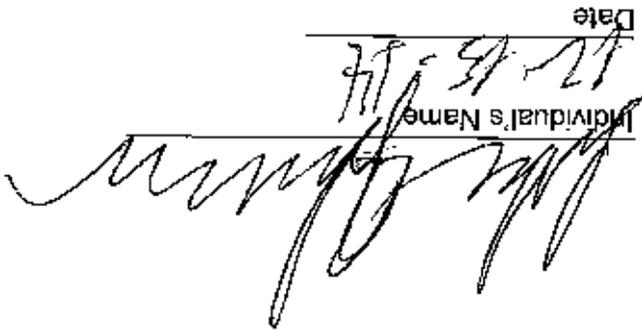
\$58.87 Employee Only  
 \$87.73 Employee + 1  
 \$186.99 Employee + Family  
 NO to MFC Wellness/Preventive Plan

Weekly Rates



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

\_\_\_\_\_  
 Individual's Name  
 \_\_\_\_\_  
 Date  
 12-15-14



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.

**DRUG AND ALCOHOL TESTING CONSENT FORM**

Employee's Signature: *[Handwritten Signature]*  
Date: *12-15-14*

Employee Name (Please Print) Luke Johnson

**Acknowledgement of Receipt Antiharassment Policy**  
I certify that I have received a copy of Employer Solutions Staffing Group's Antiharassment Policy. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at 952.835.1288/1.866.496.7573 with any questions I may have about this policy. I agree to comply with ESSG's policy on Antiharassment and understand failure to comply is grounds for disciplinary action, up to and including termination.  
I also agree that if at any time during my employment I am involved in any employment dispute or I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, marital, sexual orientation or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact my supervisor, manager, director or ESSG's Human Resource Department at 952.835.1288/1.866.496.7573 in order to obtain assistance in the resolution of such matters.



**RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT**

This is to acknowledge that I have read the Employer Solutions Staffing Group LLC Temporary Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities and obligations of my employment with the company. I understand and agree that it is my responsibility to abide by the rules, policies and standards set forth in the Handbook.

I also acknowledge that my employment with ESSG is not for a specified period of time and can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no manager or employee has the authority to enter into an employment agreement, express or implied, providing for employment other than at-will.

I also acknowledge that, except for the policy of at-will employment, ESSG reserves the right to revise, delete and add to the provisions of this Employee Handbook. All such revisions, deletions or additions must be in writing and must be signed by the CEO of the company. No oral statements or representations can change the provisions of this Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company, with or without cause or notice, at any time. No implied contract concerning any employment-related decision, term of employment or condition of employment can be established by any other statement, conduct, policy or practice.

I understand the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and ESSG concerning the duration of my employment, the circumstances under which my employment may be terminated and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings and representations concerning my employment with the company.

If I have questions regarding the content or interpretation of this Handbook, I will bring them to the attention of ESSG.

DATE 12/15/11

EMPLOYEE NAME Mike James Johnson  
EMPLOYEE SIGNATURE [Signature]  
ESSG REPRESENTATIVE Ben Robbins

PLEASE PRINT



**ACKNOWLEDGMENT**

The associate handbook was reviewed with me, and I have received my personal copy. I also acknowledge that I have been given the opportunity to ask questions and express concerns during my orientation. Additionally, I understand and support the following:

1. This handbook is intended as a guide and not an employment agreement that creates a contractual relationship, and that the employment relationship may be terminated at the will of either party at any time.

2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.

3. I agree to notify my CMG/ESSG Consultant immediately of any change in my personal data such as phone number, address, emergency notification, etc.

4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my CMG/ESSG Consultant.

Date:

12-15-14

Associate's Signature:

*Mike Johnson*

Associate's Printed Name:

Mike Johnson

Orientation provided by:

*Genevieve*