

DOH		ROP	Work Site Loc.	WC Code
For ESSG Client Use				
Emergency Contact Info	Background Release Form	Background Results	Unemployment Letter (if applicable)	ESC Application
DOH	NHW	1-9	8850	W4
For ESSG Office Use Only				

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

Name (Print or type) Judith N. Kirk  
 Applicant's Signature *Judith N. Kirk*  
 Date 01/20/15

If hired, I agree to abide by the policies and procedures of ESSG.

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.

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 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 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.

**Applicant Certification and Authorization**

Are you legally authorized to work in the United States of America?  YES  NO

All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

Staffing Agency/Recruitment Partner CMG  
 Phone Number 720-289-5089 Email Address judithk08@gmail.com  
 City/State/Zip Arvada, CO 80004  
 Street Address 6002 Garrison St. Apt/Ste —  
 Last Name Kirk First Name Judith Middle Initial N.

Personal Data-- PLEASE PRINT LEGIBLY IN INK

# New Hire Application

7301 Ohms Lane Suite 405  
 Edina, MN 55439  
 Tel: 952.835.1288 • Fax: 952.835.1255  
 www.esgstaffingsolutions.com

empoyer solutions staffing group.<sup>sm</sup>  
 Leveraging Resources in a Changing Market



Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes. Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,050 and includes more than \$500 of unearned income (for example, interest and dividends). Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

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

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

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

Complete all worksheets that apply. For accuracy, complete all worksheets that apply. 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.

Employee's Withholding Allowance Certificate

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

Separate here and give Form W-4 to your employer. Keep the top part for your records.

For accuracy, complete all worksheets that apply. 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.

1 Your first name and middle initial: Judith N. Kirk
2 Your social security number: 391-06-5837
3 Single (checked), Married (unchecked)

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2): 1
6 Additional amount, if any, you want withheld from each paycheck: \$ 0
7 I claim exemption from withholding for 2015, 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.

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)

Employee's signature: [Signature]
Date: 01/20/15
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.

OMB No. 1545-0074
2015

Department of the Treasury
Internal Revenue Service

Form W-4

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

Cat. No. 102200



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

Revision Date: 09/06/12  
Expiration Date: 10/01/14

Employee Name: Kirk Judith N.  
Last First Middle  
Date of Birth 07/01/1989

Social Security Number: 391 - 06 - 5837  
Date of Hire: 01/21/15 (MM/DD/YYYY)

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

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

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

Print Name of Employer (or Designated Representative)      Official Title

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

Business or Organization Name      Employer Phone Number

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

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

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

STOP Employer Completes Next Page STOP

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): 01/20/15
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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: \_\_\_\_\_

3-D Barcode Do Not Write in This Space

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): 07/01/1989		U.S. Social Security Number: 391-06-5837		E-mail Address: gukirkos@gmail.com		Telephone Number: 720-289-5089	
Address (Street Number and Name): 6602 Garrison St.		Apt. Number: /		City or Town: Arvada		State: CO	
Zip Code: 80004		Last Name (Family Name): Kirk		First Name (Given Name): Judith		Middle Initial: N	
Other Names Used (if any):		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.)					

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.

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



# Employment Eligibility Verification

U.S. Citizenship and Immigration Services  
 Department of Homeland Security  
 OMB No. 1615-0047  
 Form I-9  
 Expires 03/31/2016

Signature of Employer or Authorized Representative:	Date (m/d/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)(m/d/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.

<b>A.</b> New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial (To be completed and signed by employer or authorized representative.)	<b>B.</b> Date of Hire (if applicable) (m/d/yyyy)
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Last Name (Family Name) _____ First Name (Given Name) _____ Employer's Business or Organization Name <b>EMPLOYER SOLUTIONS STAFFING GROUP LLC</b>	Employer's Business or Organization Address (Street Number and Name) <b>7301 OHMS LANE SUITE 405</b> City or Town <b>EDINA</b> State <b>MN</b> Zip Code <b>55439</b>
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Signature of Employer or Authorized Representative	Date (m/d/yyyy)	Title of Employer or Authorized Representative
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The employee's first day of employment (m/d/yyyy): \_\_\_\_\_ (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 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.

**Certification**

Do Not Write in This Space 3-D Barcode	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> <tr><td style="width:33%;">Document Title:</td><td style="width:33%;">Document Number:</td><td style="width:33%;">Expiration Date (if any)(m/d/yyyy):</td></tr> </table>	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):	Document Title:	Document Number:	Expiration Date (if any)(m/d/yyyy):
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**Employee Last Name, First Name and Middle Initial from Section 1:**

**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.)

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

**DISCLOSURE REGARDING BACKGROUND INVESTIGATION**

Employer Solutions Staffing Group LLC (ESSG) may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you 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 credit history, criminal history, social security number, 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 compiled about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be 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.orange treescreening.com](http://www.orange treescreening.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.orange treescreening.com](http://www.orange treescreening.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: [Signature] Date: 01/20/15

**BACKGROUND INFORMATION**

Last Name: Kirk First: Judith Middle: N.  
 Other Names/Aliases: \_\_\_\_\_  
 Social Security #: 391-06-6837  
 Date of Birth (mm/dd/yyyy)\*: 07/01/1989  
 Driver's License #: K620-4346-9741-04  
 State of Driver's License: WI  
 Present Address: 6002 Garrison St.  
 Telephone # (Primary): 780-289-5089  
 City/State/Zip: Arvada, CO 80004

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

**DISCLOSURE AND CONSENT CONCERNING CONSUMER AND INVESTIGATIVE CONSUMER REPORTS**

This form, which you should read carefully, has been provided to you because CMG may request Consumer Reports and/or Investigative Consumer Reports from a consumer reporting agency. The Company will use any such report(s) solely for employment-related purposes. Consumer Reports or Investigative Consumer Reports will be obtained from CSS Test, Inc. ("CSS Test"), located at 400 Laurel Oak Road, Suite 102, Voorhees NJ, 08043. They can be contacted at 856-627-5600. Under the provisions of the Fair Credit Reporting Act, 15 USC, Section 1681 et seq., the Americans with Disabilities Act, the Drivers Privacy Protection Act and all other applicable federal, state, and local laws, I hereby authorize and permit CSS Test, Inc., to obtain a consumer report and/or an investigative consumer report which may include the following: Reports may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include, but are not limited to: credit reports, social security number, criminal records checks, public court records checks, including civil, driving records, educational records, verification of employment positions held, workers compensation records, personal and professional references, licensing, certification, etc. The information contained in these reports may be obtained by CSS Test from private or public record sources including sources identified by you in your job application or through interviews or correspondence with your past or present coworkers, neighbors, friends, associates, current or former employers, educational institutions or other acquaintances.

**Additional State Law Notices:** If you live or are applying for a job in California, Maine, New York or Washington, please note:

**California** residents, under section 1786.22 of the California Civil Code, you may view the file maintained on you by CSS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at CSS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

**Maine:** You have the right, upon request, to be informed of whether an investigative consumer report was requested, and if one was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from the Company, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any such reports.

**New York:** You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may inspect and receive a copy of the report by contacting that agency.

**Washington State:** If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

**CONSENT**

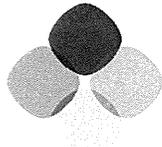
I have carefully read and understand this Disclosure and Consent form and, by my signature below, consent to the release of consumer and/or investigative consumer reports, as defined above, to the Company in conjunction with my application for employment, if any, may be utilized for the purpose of obtaining the consumer application or otherwise disclosed to the Company by me before, during or after my employment, if any, may be utilized for the purpose of obtaining the consumer reports or investigative consumer reports requested by the Company. I understand that if the Company hires me, it may request a consumer report and/or an investigative consumer report about me, as defined above, for employment-related purposes during the course of my employment. I understand that my consent will apply throughout my employment, to the extent permitted by law, unless I revoke or cancel my consent by sending a signed letter or statement to the Company at any time. This Disclosure and Consent form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by the Company.

Applicant Last Name Kirik First Judith Middle Noomi  
Social Security # 391-06-5837 Date of Birth (for ID purposes only) 07/01/1989  
Drivers License Number and State of Issue RG60-4218-9741-04  
Present Address 6062 Garrison St.  
City/State/Zip Arvada, CO. 80004  
Applicant Signature Judith Kirik Date 01/20/15  
 I wish to receive a free copy of any Consumer Report and/or Investigative Consumer Report on me that is requested.

**CALIFORNIA, MINNESOTA AND OKLAHOMA APPLICANTS ONLY:**

**CSS Inc.**

400 Laurel Oak Road, Suite 102, Voorhees, NJ 08043 Tel: 1-856-627-5600 Fax: 1-856-627-5699



# Importante/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.

—ACUERD/SE ACUERDA—

Name/Nombre (con letra de molde): *Judith Kirk*

Signature/Firma: *Judith Kirk*

# 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: *Jessie Kirk*

Printed Name: Jessie Kirk

TAX CREDIT QUESTIONNAIRE



EMPLOYER SECTION:

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

EMPLOYEE SECTION:

Employee Name:	Street Address:	City/State:	Zip:
Judith Kirk	6062 Garrison St.	Brvada, CO	80001
SS#:	Date of Birth:	Age:	Have you worked for this company before? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
391-04-5837	07/01/1989	25	
Name of the person receiving benefits:	Relationship to you:	County:	State:

Please complete all questions, and sign and date the form.

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: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_

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

County: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_

2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.)

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

County: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_

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 information below.)

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

County: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_

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.)

Name of Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_

5. Are you a Veteran of the U.S. Military? \*If yes, please provide a copy of your DD-214 and letter of separation. (If yes, please provide information below. If no, please continue to question #6.)

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

Branch of Service: \_\_\_\_\_

Are you entitled to or are you receiving compensation for a service-connected disability?  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? 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 please provide a copy of your CDIB 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 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: *Judith Kirk*

Date: 01/20/15

**STATEMENT OF CONFIDENTIALITY**

This agreement made this 20<sup>th</sup> day of January, 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and \_\_\_\_\_ hereafter referred to as "employee".

**WITNESSETH:**

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

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

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

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

**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 DUDITH KIRK Social security number ▶ 3911-06-5837

Street address where you live 10002 GARRISON ST.

City or town, state, and ZIP code ARVADA, CO. 80004

County JEFFERSON Telephone number 720-289-5089

If you are under age 40, enter your date of birth (month, day, year) 07/01/1989

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 ▶ [Signature] Date 01/20/15

Form 8850 (Rev. 1-2012) Cat. No. 22851L For Privacy Act and Paperwork Reduction Act Notice, see page 2.

**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: Judith Kirk SSSN# (last 4 digits) 5837 Effective Date: \_\_\_\_\_

**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**

T  
N  
U  
C  
C  
A

Update Bank Account

Bank Name: \_\_\_\_\_

Routing# \_\_\_\_\_

Account# \_\_\_\_\_

Account Type:  Checking  Savings  Other \_\_\_\_\_

I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.

Initial \_\_\_\_\_ Date \_\_\_\_\_

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

- 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.

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: Judith M.I. N. Last Name: Kirk

Street Address (PO BOX NOT ACCEPTABLE): 1006A GARRISON ST.

City: Arvada State: CO. Zip: 80004

Cell Phone (mobile): 720-289-5089

Social Security#: 071011989

**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.

**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: unkirk08@gmail.com

this information will only be used to send your paystubs electronically

Employee's Signature: Judith Kirk Date: 01/20/15

## ENROLLMENT FORM

ESC NAV\*SAD P2M v15.0

### REQUIRED EMPLOYEE INFORMATION

**PRINT USING BLACK or BLUE INK**  
(Must Be Filled Out)

Social Security Number 391-06-5837  
Date of Birth 02/01/1989 Sex  M  F

Name JUDITH RIKK  
Street Address 6004 GARRISON ST.  
City BRVADA State CO Zip 80004

Home Phone 720-289-5089

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.

### OPTION 1 FIXED INDEMNITY PLAN

**Weekly Rates**  
 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**  
 YES \$0.60 Employee Only  
 YES \$0.90 Employee + 1  
 NO \$1.80 Employee + Family

**SHORT-TERM DISABILITY**  
 YES \$4.20 Employee Only  
 NO  
 Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

**OPTION 2  
MGC WELLNESS/PREVENTIVE PLAN**  
 82193010-M-EMP Monthly Rates  
 \$58.87 Employee Only  
 \$87.73 Employee + 1  
 \$186.99 Employee + Family  
 NO to MGC Wellness/Preventive Plan

Signature Judith Rikk Date 01/20/2015  
 I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

**EMERGENCY CONTACT INFORMATION**

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

Employee Name: Dudith Kirk

Address: 6002 Garrison St. Arvada, CO 80004

Home Phone: 720-259-5089

(cell)

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

<p>Home Phone:</p> <p>Cell Phone: <u>720-822-8593</u></p> <p>Work Phone:</p>	<p><b>Contact #1</b></p> <p>Name: <u>Robynn Smith</u></p> <p>Relationship: <u>roommate</u></p>
<p>Home Phone:</p> <p>Cell Phone: <u>720-238-7795</u></p> <p>Work Phone:</p>	<p><b>Contact #2</b></p> <p>Name: <u>Leonard Smith</u></p> <p>Relationship: <u>close friend's father</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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USA WI

**WISCONSIN DRIVER LICENSE REGULAR**

4d DL K620-4348-9741-04

1. KIRK

2. JUDITH N  
421 WASHINGTON CT #A  
SHEBOYGAN, WI 53081

3. DOB 07/01/1989 46 EXP 07/01/2018

16 SEX F 48 ISS 04/23/2013

18 HGT 5-03" 18 EYES BLU

17 WGT 135 lb 18 HAIR BRO

9 CLASS D 9a END NONE

5 DO OTBQL2013042313070560





DOB ON

**SOCIAL SECURITY**

HEALTH SERVICES

791-06-5887

THIS NUMBER HAS BEEN ESTABLISHED FOR

JUDITH N ADML KIRK

JUDITH N ADML KIRK

*Judith N. Kirk*

SIGNATURE

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security  
E-Verify  
Report Prepared: 01/20/2015  
Page: 1 of 1

Case Verification Number: 2015020142754DB

Case Information:

Employee Information:

Last Name: Kirk  
First Name: Judith  
Middle Initial:  
Social Security Number: \*\*\* \*\* 5837  
Citizenship Status: A citizen of the United States  
Date of Birth: 07/01/1989  
Email Address:

Document Information:

List B Document: Driver's license or ID card issued by a U.S. state or outlying possession  
Document Name: Driver's license  
Driver's License or ID Card Number:  
List C Document: Social Security Card  
Document State: Wisconsin  
Document Expiration Date: 07/01/2018  
1-94 Number:

Additional Information:

Hire Date: 01/20/2015  
Employer Case ID: Three-Day Rule - Other:  
Three-Day Rule Reason: EPOR4912  
Submitted On: 01/20/2015

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 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:

## PAYCARD ENROLLMENT FORM

You will be issued a temporary ATM Debit Card and a Debit MasterCard will be mailed to your home address within 7-10 days. Once you activate your Debit MasterCard, the funds from your temporary ATM Debit Card (please keep it as a back-up card) will automatically transfer to your Debit MasterCard.

Please attach a copy of your Social Security Card as a REQUIRED government-issued form of identification.

Please indicated if this is a **NEW** New or **REPLACEMENT** card

**Card Number:**

4853 - 4001 - 3712 - 6142

### Global Cash Card - Account Owner Information (Please Print Legibly)

First Name: Dudith Kirk M.I.: N Last Name: Kirk

Street Address (No PO Box): 1004 Garrison St. Apartment #: —

City: Arnuda, CO State: CO Zip Code: 80024

Home Telephone: ( ) ( ) ( ) Cell Number (Text Notification): ( ) ( ) ( )

Date of Birth (MM/DD/YYYY): 07 01 1989 Social Security Number: 391 06 5837

Email Address: dudirk08@gmail.com

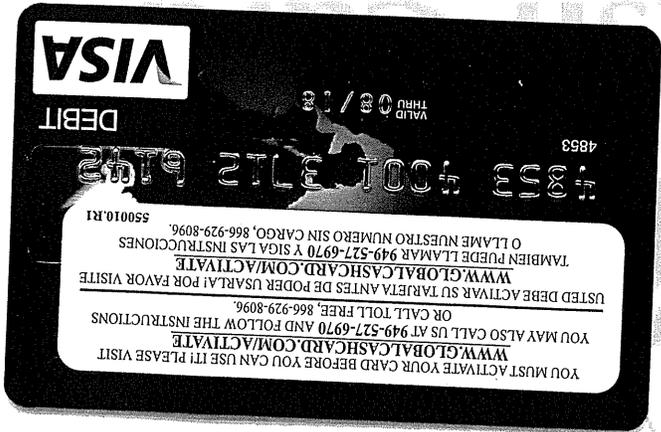
Please initial one of the following:  
 I would like to receive my paystub voucher printed: \_\_\_\_\_  
 I would like to receive my paystub voucher by email each week, until further notice: OK

Employee Signature: Maria King Date: 01/20/15

LOCATION INFORMATION (All fields must be completed by a company representative)

ESSG Location: CMG - Accellent Employee given Temporary Card & Date: \_\_\_\_\_

## CONGRATULATIONS! ACTIVATE YOUR NEW Global Cash Card paycard!



1. **Activate your card:** Online at [www.globalcashcard.com/activate](http://www.globalcashcard.com/activate) or by calling 866-929-8096.
2. **Use your card:** Sign the back of the paycard and start using it everywhere!
3. **Manage your card:** Manage your funds, your way! Go online to [www.globalcashcard.com](http://www.globalcashcard.com) and click on **User Login** to manage your paycard account online.

## Your Card. Your Money. Right Now.

- **NO FEE purchases** - Pay retailers, restaurants, gas stations, online merchants, and more by using your paycard as a signature or credit type of purchase!
- **Get cash back** - Use your PIN for purchases and get cash back from merchants.
- **Get cash at ATMs** - Get cash at millions of ATM's worldwide.
- **Alert notifications** - Go to your online account at [www.globalcashcard.com](http://www.globalcashcard.com) to set up text or e-mail alerts.