SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security
E-Verify

Report Prepared: 10/06/2011
Page: 1 of 1

Case Verification Number: 2011279134039XL

Case Information:

Employee Information:

Last Name:	Gordon	First Name:	Gail
Middle Initial:	L	Maiden Name:	
Social Security Number:	*** ** 8558	Date of Birth:	11/11/1953
Citizenship Status:	A citizen of the United States		

Document Information:

List B Document:	Driver's license or ID card issued by a U.S. state or outlying possession	List C Document:	Social Security Card
Document Name:	Driver's license	Document State:	Minnesota
Driver's License or ID Card Number:		Document Expiration Date:	11/10/2011
Alien Number:		I-94 Number:	

Additional Information:

Hire Date:	10/06/2011	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	TKOS8853	Submitted On:	10/06/2011

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: | Maiden Name:
Social Security Number: | Date of Birth:
Resubmitted By: | Resubmitted On:

Case Result from SSA (after Resubmission):

Case Result:

Request Name Review:

Comments:
Submitted By: | Submitted On:

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

Case Result: | Response Date:

Employee Referred to DHS:

Referred By: | Referred On:

Case Result from DHS (after DHS Tentative Nonconfirmation):

Case Result: | Response Date:

Photo Matching Results:

Determination:

Employee Referred to DHS (Additional):

Referred By: Referred On:

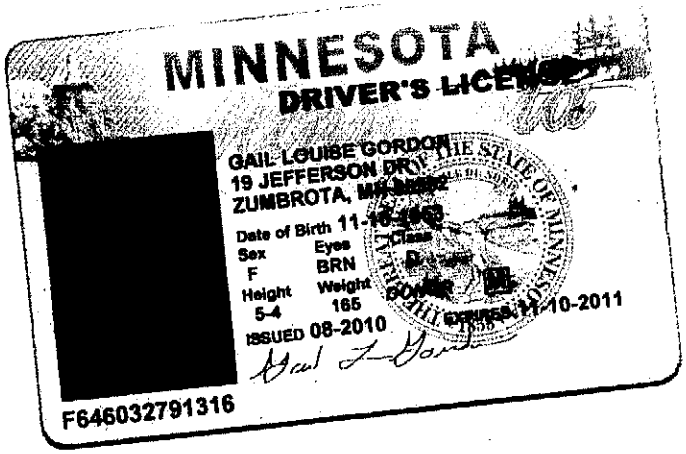
Case Result from DHS (after Additional DHS Tentative Nonconfirmation):

Case Result: Response Date:

Case Closure:

Closure Statement:
Closed By: Closed On:

SENSITIVE BUT UNCLASSIFIED


MINNESOTA
DRIVER'S LICENSE
GAIL LOUISE GORDON
19 JEFFERSON DR
ZUMBROTA, MN
Date of Birth 11-
Sex F
Eyes BRN
Class D
Height 5-4
Weight 165
ISSUED 08-2010
EXPIRES 11-10-2011
F646032791316

Employer Solutions Staffing Group LLC

7301 Ohms Lane / Suite 405
Edina, MN 55439
T:952.835.1288 / F:952.835.4881

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Gordon **First Name** Gail **Middle Initial** L

Street Address 19 Jefferson Drive

City/State/Zip Zumbrota, MN 55992

Home Phone 507 732 7855 **Cell / Message Phone** 507 271 0592

Company/Employer ESSG

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.

Gail L. Gordon — Name (Print or type)

Gail L Gordon — Applicant's Signature

10-6-11 — Date

A copy or facsimile will be considered the same as an original signature.

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	5 Day Letter (If applicable) _____	ESC Application _____

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

Name: Gail L. Gordon

Address: 19 Jefferson Drive, Zumbrota, MN

Home Phone: 507 732 7855

Person(s) to contact in case of an emergency on the job (in order of preference):

1. **Name:** Larry D. Gordon

   Phone (work): 507-732 4095

   Phone (home): 507 732 7855

2. **Name:** Glennis Gordon

   Phone (work):

   Phone (home): 507 732 5454

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

Employer Solutions Staffing Group LLC

STATEMENT OF CONFIDENTIALITY

This agreement made this 6th day of Oct, 2011, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Gail Gordon 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.

Gail L Gordon
Employee Signature

Kelsey Adelkind
Employer Solutions Staffing Group LLC, Representative

Form W-4 (2011)

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 2011 expires February 16, 2012. 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 $950 and includes more than $300 of unearned income (for example, interest and dividends).

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

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

Head of household. Generally, you may 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. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 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. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children	G	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H	0

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 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.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2011

1 Type or print your first name and middle initial.	Last name	2 Your social security number
Gail L	Gordon	469 68 8558
Home address (number and street or rural route)	3 ☐ Single ☒ Married ☐ Married, but withhold at higher Single rate.	
19 Jefferson Drive	**Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	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. ▶ ☐	
Zumbrota MN 55992		

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5 0
6	Additional amount, if any, you want withheld from each paycheck	6 $ 0
7	I claim exemption from withholding for 2011, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

Employee's signature (This form is not valid unless you sign it.) ▶ Gail L Gordon **Date** ▶ 10-6-11

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)

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

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

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

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Gordon	Gail	L	Craig

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*
19 Jefferson Drive, ~~Zumbrota, MN 55992~~		11/10/1953

City	State	Zip Code	Social Security #
Zumbrota	MN	55992	469 68 8558

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

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

- [x] A citizen of the United States
- [ ] A noncitizen national of the United States (see instructions)
- [ ] A lawful permanent resident (Alien #) _____
- [ ] An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature: Gail L Gordon Date *(month/day/year)*: 10-6-11

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title:		Drivers license		Social Sec. Card
Issuing authority:		State of Minnesota		Social Sec. Admin
Document #:		F6440 0032 79316		469-68-8558
Expiration Date *(if any)*:		11-10-2011		
Document #:				
Expiration Date *(if any)*:				

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* 10/6/11 **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Teresa C Koski	Teresa C Koski	Admin Asst

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*
Employer Solutions Staffing Group 7401 OHMS LANE, SUITE 405 EDINA, MN 55439	10-6-2011

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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

Signature of Employer or Authorized Representative	Date *(month/day/year)*

Background Investigation Information Release Form

Please read this form carefully and be aware that by allowing Employer Solutions Staffing Group LLC to investigate your background with state and federal agencies, you will be waiving and releasing all claims for damages you might sustain arising out of the criminal and driving record background check and review.

I understand that a successful criminal and driving record background investigation is a condition of my employment by Employer Solutions Staffing Group LLC to work at facilities of: Rachel Foods,
and, further, that Employer Solutions Staffing Group may, at its discretion, conduct periodic criminal and driving record background investigations on me during the course of my employment with Employer Solutions Staffing Group.

I agree to waive and relinquish all claims I may have against Employer Solutions Staffing Group LLC and its officers, agents, servants and employees as a result of my participation in any criminal and driving record background investigation.

I do hereby fully release and discharge Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims from damages that I may have or that may accrue to me on account of the results of any aspect of any criminal and driving record background investigation.

I further agree to indemnify and hold harmless and defend Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims resulting from damages sustained by me or arising out of, connected with, or in any way associated with, any of the activities of any criminal and driving record background investigation and review.

I have read and fully understand this Waiver and Release of All Claims.

469 68 8558	F64603279131l6	MN
Social Security Number	Driver's License No:	State
Gordon	Gail	L
Last Name	First Name	M.I

Craig, Schmike, Luck, Bayden, Gronseth
Maiden and/or Other Last Names Used

19 Jefferson Drive	Zumbrota, Goodhue	MN 55992
Current Address	City and County	State and Zip Code

11-10-1953	Circle One: Male / (Female)
Date of Birth	

Signature: Gail L Gordon Date: 10-6-11

Form **8850**
(Rev. August 2009)
Department of the Treasury
Internal Revenue Service

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

▶ See separate instructions.

OMB No. 1545-1500

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

Your name Gail L. Gordon Social security number ▶ 469 68 8558

Street address where you live 19 Jefferson Drive

City or town, state, and ZIP code Zumbrota, MN 55992

County Goodhue Telephone number (507) 732-7855

If you are under age 40, enter your date of birth (month, day, year) _____

1 ☐ Check here if you are completing this form **before** August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.

2 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

3 ☐ 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 discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and,** for at least 4 weeks during the past year, I received unemployment compensation.
- I am at least age 16 but **not** age 25 or older, **and:**
  - **a** During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
  - **b** During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
  - **c** I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate **or** I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability **and,** during the past year, you were:

- Discharged or released from active duty in the U.S. Armed Forces, **or**
- Unemployed for a period or periods totaling at least 6 months.

5 ☐ 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 ▶ Gail L Gordon **Date** 10/6/11

Form A (revised 07/09) **WORK OPPORTUNITY TAX CREDIT**

PLEASE CHECK "YES" OR "NO" AND ANSWER ALL QUESTIONS

Name Gail L. Gordon
Address 19 Jefferson Drive
City Zumbrota State MN Zip 55992 Social Security # 469 68 8558
Date of Birth 11/10/1953 Age 57

Please CHECK ONE ANSWER for each of the following questions, and complete question #5:

1. Have you or any family member living with you received Temporary Assistance to Needy Families (TANF) or Aid to Families with Dependent Children (AFDC) during the past 24 months? **Yes** ☐ **No** ☒

2. Have you or any family member living with you received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) at any time during the past fifteen (15) months? **Yes** ☐ **No** ☒

3. Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days? **Yes** ☐ **No** ☒

4. Are you part of the Ticket to Work program? **Yes** ☐ **No** ☒

5. **Name of person who received benefits** _____
Relationship _____ **City & State where benefits received** _____

6. Are you a veteran? **Yes** ☐ **No** ☒ and Disabled due to service? **Yes** ☐ **No** ☒
Service Dates: From: _____ To: _____ Branch: _____

7. Have you been unemployed at any time during the last 12 months? **Yes** ☐ **No** ☒
If yes, dates of unemployment: From: _____ To: _____
Did you receive unemployment compensation at any point during your unemployment?
If yes, dates received compensation: From: _____ To: _____ **Yes** ☐ **No** ☐

8. Have you been convicted of a felony or released from prison in the last 12 months?
Date of Conviction: _____ Date of Release: _____ **Yes** ☐ **No** ☒
Parole Officer's Name: _____ Parole Officer's Phone # _____

9. Have you received rehabilitation services from a State approved or Department of Veterans Affairs approved *Vocational* rehabilitation agency? **Yes** ☐ **No** ☒
Name of Agency _____ Phone # _____
Address of Agency _____ Counselor's Name _____

10. Have you attended High School, College or Technical School for more than an average of 10 hours per week at any time during the last 6 months? **Yes** ☐ **No** ☒

11. Did you receive a high school diploma or GED? If yes, date received: _____ **Yes** ☐ **No** ☒
Have you been employed or been admitted to technical school or college since then? **Yes** ☐ **No** ☒

12. How much in gross wages have you earned TOTAL in the past six months? $ Ø

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, or the Department of Labor.

→ NEW HIRE SIGNATURE Gail L Gordon DATE 10-6-11

Questions below to be completed by manager
Starting Wage 7.50 Position Production
Has employee worked for this company before? no If yes, date and location _____

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: November 30, 2011

YOUTH SELF-ATTESTATION FORM
Work Opportunity Tax Credit Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with Form ETA 9061 for each certification request filed.

New Hire Name: Gail L. Gordon

Social Security Number: 469 68 8558 Date of Birth: 11 | 10 | 1953

Employer Name: Employer Solutions Staffing Group

Employer Federal ID (EIN) Number: 26-2726508

Please check all the statements that apply to you. Sign and date this form where indicated below.

☑ In the past 6 months, I have not attended a secondary, technical or postsecondary school for more than an average of 10 hours per week, not counting periods during which the school is closed for scheduled vacations.

☐ I do not have a High School Diploma or GED certificate.

☑ I have a High-School diploma or GED certificate awarded more than 6 months ago and I have not attended or been admitted to a technical or post-secondary school. I also have not held a job (other than occasionally) since receiving my High-School diploma or GED certificate.

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

New Hire's Signature: Gail L Gordon Date 10-6-11

Privacy Act Notice:
The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form, including the Social Security Number, will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OM B control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of Adult Services, Room S-4209, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

Employer Solutions Staffing Group LLC

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.

It is your responsibility to contact ESSG (for instance, by calling (507) 398.4567 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 GLG (Initial)

Gail L Gordon — 10-6-11

Employee Signature: Date:

Gail L. Gordon

Employee (please print your name here)

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: Gail L Gordon

Printed Name: Gail L. Gordon

[redacted]

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.

Employee Name (Please Print)

Gail L. Gordon

Employee's Signature:

Gail L Gordon Date: 10-6-11

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 10-6-11

EMPLOYEE NAME Gail L. Gordon
PLEASE PRINT

EMPLOYEE SIGNATURE Gail L Gordon

ESSG REPRESENTATIVE Kelsey Adkisson

☑ 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 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 ESSG Consultant.

Date: 10-6-11

Associate's Signature: Gail L Gordon

Associate's Printed Name: Gail L. Gordon

Orientation provided by: Kelsey Adkins

*219301-EMP | OFFICE USE ONLY ReHire Date __/__/____

EMPLOYEE INFORMATION (Must Be Filled Out)

ENROLLMENT FORM - 10k PLAN

USE BLACK or BLUE INK ONLY

Social Security Number 469-68-8558

Date of Birth 11/10/1953 Sex M [F]

Name Gail L. Gordon

Street Address 19 Jefferson Drive

City Zumbrota State MN Zip 55992

Home Phone 507-732-7855

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.
4.

- You MUST enroll in the Medical Insurance Plan before adding STD or Term Life.
- Your coverage level for Term Life will be identical to your medical plan selection.

BENEFIT SELECTION

Weekly Rates

MEDICAL

- ☒ $20.91 Employee Only
- ☐ $42.44 Employee +1
- ☐ $56.67 Employee + Family
- ☐ NO to MEDICAL, TERM LIFE, and STD benefits .

DENTAL

- ☒ $5.99 Employee Only
- ☐ $11.98 Employee +1
- ☐ $19.77 Employee + Family
- ☐ NO

TERM LIFE

- ☒ YES
- ☐ NO

$0.60 Employee Only
$0.90 Employee +1
$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.

REQUIRED DEPENDENT INFORMATION

Name ____
Social Security Number ___-__-____
Date of Birth __/__/____ Sex M F
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

Name ____
Social Security Number ___-__-____
Date of Birth __/__/____ Sex M F
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

Name ____
Social Security Number ___-__-____
Date of Birth __/__/____ Sex M F
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

Name ____
Social Security Number ___-__-____
Date of Birth __/__/____ Sex M F
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

BENEFICIARY INFORMATION

For Term Life and Accidental Death & Dismemberment please write in your Beneficiary information.

NAME OF BENEFICIARY
Larry D. Gordon

RELATIONSHIP
Spouse

Accidental Death & Dismemberment is part of the Medical 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 declination of coverage.

▶ **Signature** Gail L. Gordon Date 10/06/2011

Form: ESC CU(ESG) 10K v10.3