

employer solutions staffing group  
Leveraging Resources in a Changing Market

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

## New Hire Application

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

Last Name Fong First Name Manny Middle Initial S  
Street Address 6452 Silver Mesa dr Apt/Ste C  
City/State/Zip Littleton CO 80130 Social Security Last Four XXX-XX-5475  
Phone Number 720-771-8327 Email Address huskerfong@yahoo.com  
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) manuel fong Applicant's Signature [Signature] Date 7/7/17

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

| For ESSG Office Use Only        |                                  |                             |                                                 |                          |
|---------------------------------|----------------------------------|-----------------------------|-------------------------------------------------|--------------------------|
| DOH _____                       | NHW _____                        | I-9 _____                   | 8850 _____                                      | W4 _____                 |
| Emergency Contact Info<br>_____ | Background Release Form<br>_____ | Background Results<br>_____ | Unemployment Letter<br>(If applicable)<br>_____ | ESC Application<br>_____ |
| For ESSG Client Use             |                                  |                             |                                                 |                          |
| DOH _____                       | ROP _____                        | Work Site Loc. _____        | WC Code _____                                   |                          |



Revision Date: 09/01/14  
Expiration Date: 10/01/17

**Affirmation of Legal Work Status**

Pursuant to § 8-2-122, Colorado Revised Statutes

Employee Name: Fong Manvel S 3/4/75  
Last First Middle Date of Birth

Social Security Number: 507-11-5475 Date of Hire: 07/07/17 (MM/DD/YYYY)

In accordance with § 8-2-122, C.R.S., within 20 calendar 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.

Andrea Findley  
Print Name of Employer (or Designated Representative)

Executive Assistant  
Official Title

Andrea Findley  
Signature of Employer (or Designated Representative)

07/07/2017 (MM/DD/YYYY)  
Date Signed by Employer

Employer Solutions Staffing Group  
Business or Organization Name

952-835-1288  
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.

# Form W-4 (2017)

**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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 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.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you aren't 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 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.

**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. 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 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 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (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/w4](http://www.irs.gov/w4).

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

|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |   |          |
|---|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|----------|
| A | Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | A | _____    |
| B | Enter "1" if: <ul style="list-style-type: none"><li>• You're single and have only one job; or</li><li>• You're married, have only one job, and your spouse doesn't work; or</li><li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li></ul> . . . . .                                                                                                                                                                                                                                                       | B | _____    |
| C | Enter "1" for your <b>spouse</b> . 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 <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                              | D | _____    |
| E | Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                       | E | _____    |
| F | Enter "1" if you have at least \$2,000 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                | F | _____    |
| G | <b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"><li>• If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have two to four eligible children or <b>less</b> "2" if you have five or more eligible children.</li><li>• If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.</li></ul> | G | _____    |
| H | Add lines A through G and enter total here. ( <b>Note:</b> This may be different from the number of exemptions you claim on your tax return.) ▶                                                                                                                                                                                                                                                                                                                                                                                                                 | H | <u>2</u> |

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 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.

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                  |  |                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|
| <b>Form W-4</b><br>Department of the Treasury<br>Internal Revenue Service                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>Employee's Withholding Allowance Certificate</b>                                                                                                                                                                                                              |  | OMB No. 1545-0074                                   |  |
| ▶ <b>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.</b>                                                                                                                                                                                                                                                                                                   |  | <b>2017</b>                                                                                                                                                                                                                                                      |  |                                                     |  |
| 1 Your first name and middle initial<br><u>Marvel S</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Last name<br><u>Fong</u>                                                                                                                                                                                                                                         |  | 2 Your social security number<br><u>507-11-5475</u> |  |
| Home address (number and street or rural route)<br><u>6452 Silver Mesa Dr # C</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 3 <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate.<br><b>Note:</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |  |                                                     |  |
| City or town, state, and ZIP code<br><u>Littleton CO 80130</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>                                                                                            |  |                                                     |  |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5 <u>2</u>                                                                                                                                                                                                                                                       |  |                                                     |  |
| 6 Additional amount, if any, you want withheld from each paycheck . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6 \$                                                                                                                                                                                                                                                             |  |                                                     |  |
| 7 I claim exemption from withholding for 2017, and I certify that I meet <b>both</b> of the following conditions for exemption. <ul style="list-style-type: none"><li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b></li><li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</li></ul> 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<br>(This form is not valid unless you sign it.) ▶ <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Date ▶ <u>7/7/17</u>                                                                                                                                                                                                                                             |  |                                                     |  |
| 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 9 Office code (optional)                                                                                                                                                                                                                                         |  | 10 Employer identification number (EIN)             |  |



Employment Eligibility Verification  
Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS  
Form I-9  
OMB No. 1615-0047  
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

|                                                                |  |                                                   |                          |                                                          |                                              |                                                    |
|----------------------------------------------------------------|--|---------------------------------------------------|--------------------------|----------------------------------------------------------|----------------------------------------------|----------------------------------------------------|
| Last Name (Family Name)<br><u>FONG</u>                         |  | First Name (Given Name)<br><u>Manuel</u>          |                          | Middle Initial<br><u>S</u>                               | Other Last Names Used (if any)<br><u>N/A</u> |                                                    |
| Address (Street Number and Name)<br><u>6452 Silver Mesa Dr</u> |  |                                                   | Apt. Number<br><u>#C</u> | City or Town<br><u>Littleton</u>                         |                                              | State<br><u>CO</u>                                 |
| Date of Birth (mm/dd/yyyy)<br><u>03/04/1975</u>                |  | U.S. Social Security Number<br><u>507-11-5475</u> |                          | Employee's E-mail Address<br><u>lvskertong@yahoo.com</u> |                                              | Employee's Telephone Number<br><u>720-771-8327</u> |

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

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

|                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> 1. A citizen of the United States                                                                                                                                                                                                                                                                                                                                                     |
| <input type="checkbox"/> 2. A noncitizen national of the United States ( <i>See instructions</i> )                                                                                                                                                                                                                                                                                                                        |
| <input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): <u>N/A</u>                                                                                                                                                                                                                                                                                                              |
| <input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): <u>N/A</u><br>Some aliens may write "N/A" in the expiration date field. ( <i>See instructions</i> )                                                                                                                                                                                                           |
| <p>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:<br/>An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</p> <p>1. Alien Registration Number/USCIS Number: <u>N/A</u><br/>OR<br/>2. Form I-94 Admission Number: <u>N/A</u><br/>OR<br/>3. Foreign Passport Number: <u>N/A</u><br/>Country of Issuance: _____</p> |
| QR Code - Section 1<br>Do Not Write In This Space                                                                                                                                                                                                                                                                                                                                                                         |

|                                             |                                                |
|---------------------------------------------|------------------------------------------------|
| Signature of Employee<br><u>[Signature]</u> | Today's Date (mm/dd/yyyy)<br><u>07/07/2017</u> |
|---------------------------------------------|------------------------------------------------|

**Preparer and/or Translator Certification (check one):**

|                                                                             |                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> I did not use a preparer or translator. | <input type="checkbox"/> A preparer(s) and/or translator(s) assisted the employee in completing Section 1.<br>(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.) |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

|                                                           |  |                                                |                         |
|-----------------------------------------------------------|--|------------------------------------------------|-------------------------|
| Signature of Preparer or Translator<br><u>[Signature]</u> |  | Today's Date (mm/dd/yyyy)<br><u>07/07/2017</u> |                         |
| Last Name (Family Name)<br><u>[Blank]</u>                 |  | First Name (Given Name)<br><u>[Blank]</u>      |                         |
| Address (Street Number and Name)<br><u>[Blank]</u>        |  | City or Town<br><u>[Blank]</u>                 | State<br><u>[Blank]</u> |
|                                                           |  | ZIP Code<br><u>[Blank]</u>                     |                         |



Employer Completes Next Page





**Employment Eligibility Verification**  
Department of Homeland Security  
U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 08/31/2019

**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 a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

|                              |                                       |                                          |                  |                                                     |
|------------------------------|---------------------------------------|------------------------------------------|------------------|-----------------------------------------------------|
| Employee Info from Section 1 | Last Name (Family Name)<br><u>Fom</u> | First Name (Given Name)<br><u>Manuel</u> | M.I.<br><u>S</u> | Citizenship/Immigration Status<br><u>US Citizen</u> |
|------------------------------|---------------------------------------|------------------------------------------|------------------|-----------------------------------------------------|

**List A**  
Identity and Employment Authorization

OR

**List B**  
Identity

AND

**List C**  
Employment Authorization

|                                       |                                                                        |                                               |
|---------------------------------------|------------------------------------------------------------------------|-----------------------------------------------|
| Document Title                        | Document Title<br><u>CO Driver License</u>                             | Document Title<br><u>Social Security Card</u> |
| Issuing Authority                     | Issuing Authority<br><u>State of CO</u>                                | Issuing Authority<br><u>SSA</u>               |
| Document Number                       | Document Number<br><u>97-181-1446</u>                                  | Document Number<br><u>507-11-5475</u>         |
| Expiration Date (if any) (mm/dd/yyyy) | Expiration Date (if any) (mm/dd/yyyy)<br><u>03/04/2020</u>             | Expiration Date (if any) (mm/dd/yyyy)         |
| Document Title                        | <div>Additional Information</div>                                      |                                               |
| Issuing Authority                     |                                                                        |                                               |
| Document Number                       |                                                                        |                                               |
| Expiration Date (if any) (mm/dd/yyyy) |                                                                        |                                               |
| Document Title                        |                                                                        |                                               |
| Issuing Authority                     | <div>QR Code - Sections 2 &amp; 3<br/>Do Not Write In This Space</div> |                                               |
| Document Number                       |                                                                        |                                               |
| Expiration Date (if any) (mm/dd/yyyy) |                                                                        |                                               |
| Document Title                        |                                                                        |                                               |
| Issuing Authority                     |                                                                        |                                               |
| Document Number                       |                                                                        |                                               |
| Expiration Date (if any) (mm/dd/yyyy) |                                                                        |                                               |

**Certification:** I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): 07/07/2017 (See instructions for exemptions)

|                                                                                                           |                                                               |                                                                                   |             |
|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------|
| Signature of Employer or Authorized Representative<br><u>Andrea Findley</u>                               | Today's Date (mm/dd/yyyy)<br><u>07/18/2017</u>                | Title of Employer or Authorized Representative<br>Executive Assistant             |             |
| Last Name of Employer or Authorized Representative<br>Findley                                             | First Name of Employer or Authorized Representative<br>Andrea | Employer's Business or Organization Name<br>EMPLOYER SOLUTIONS STAFFING GROUP LLC |             |
| Employer's Business or Organization Address (Street Number and Name)<br>7480 FLYING CLOUD DRIVE SUITE 200 |                                                               | City or Town<br>MINNEAPOLIS                                                       | State<br>MN |
|                                                                                                           |                                                               | ZIP Code<br>55344                                                                 |             |

**Section 3. Reverification and Rehires** (To be completed and signed by employer or authorized representative.)

|                                    |                         |                |                                          |
|------------------------------------|-------------------------|----------------|------------------------------------------|
| <b>A. New Name (if applicable)</b> |                         |                | <b>B. Date of Rehire (if applicable)</b> |
| Last Name (Family Name)            | First Name (Given Name) | Middle Initial | Date (mm/dd/yyyy)                        |

**C.** If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

|                |                 |                                       |
|----------------|-----------------|---------------------------------------|
| Document Title | Document Number | Expiration Date (if any) (mm/dd/yyyy) |
|----------------|-----------------|---------------------------------------|

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

|                                                    |                           |                                               |
|----------------------------------------------------|---------------------------|-----------------------------------------------|
| Signature of Employer or Authorized Representative | Today's Date (mm/dd/yyyy) | Name of Employer or Authorized Representative |
|----------------------------------------------------|---------------------------|-----------------------------------------------|

MANUEL S FONG  
Member  
7346 243 588  
Plan ID (80840)  
1148222530  
Member ID  
Card Expires: 09/09/2024  
VA HEALTHCARE ENROLLEE  
SERVICE CONNECTED  
U.S. Department  
of Veterans Affairs  
VA  
U.S. Department of Veterans Affairs seal  
American flag graphic

Colorado ★  
Driver License  
97-181-1446 Expires: 03-04-2020  
Class: R Issued: 03-18-2015  
End: DOB: 03-04-1975  
Rest: Previous Type: N  
Ht: 6'03" Wt: 205 Eyes: BRO Sex: M  
MANUEL SALVADOR FONG  
9023 WEST CROSS DRIVE APT 17-201  
LITTLETON, CO 80123

AMERICA SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA SOCIAL SECURITY ADMINISTRATION UNITED STATES OF AMERICA

# SOCIAL SECURITY

507-11-5475

THIS NUMBER HAS BEEN ESTABLISHED FOR

MANUEL SALVADOR  
FONG

SIGNATURE

09/19/2014





SENSITIVE BUT UNCLASSIFIED

**Case Verification Number: 2017199162430MQ**

Report Prepared: 07/18/2017

**Company Information**

Company ID: 47429

Company Name: Employer Solutions Staffing Group

**Employee Information**

Last Name: Fong

First Name: Manuel

Date of Birth: 03/04/1975

Social Security Number: \*\*\* \*\* 5475

Hire Date: 07/10/2017

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: Colorado

Driver's License or ID Card Number:

Document Expiration Date: 03/04/2020

**Case Status Information**

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 07/18/2017

Case Submitted By: AFIN3846

Closed On: 07/18/2017

Closed By: AFIN3846

Closure Statement: The employee continues to work for the employer after receiving an Employment Authorized result.

SENSITIVE BUT UNCLASSIFIED

## Authorization

**Authorization:** By signing below, you authorize: (a) backgroundchecks.com ("BGC") to request information about you from any public or private information source; (b) anyone to provide information about you to BGC; (c) BGC to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) us to share those reports with others for legitimate business purposes related to your employment. BGC may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an applicant or employee with us.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

**Personal Information:** Please print the information requested below to identify yourself for BGC.

Printed name: manvel S Fong  
First Middle (☐ none) Last

Other names used: \_\_\_\_\_

Current and former addresses:

|              |              |                                             |                           |
|--------------|--------------|---------------------------------------------|---------------------------|
| <u>02/16</u> | current      | <u>6452 silver mesa dr #c, Littleton CO</u> | <u>80130</u>              |
| from Mo/Yr   | to Mo/Yr     | Street                                      | City, State & Zip         |
| <u>8/13</u>  | <u>11/16</u> | <u>9023 W cross dr 20-202</u>               | <u>Littleton CO 80128</u> |
| from Mo/Yr   | to Mo/Yr     | Street                                      | City, State & Zip         |

|            |          |        |                   |
|------------|----------|--------|-------------------|
| from Mo/Yr | to Mo/Yr | Street | City, State & Zip |
|------------|----------|--------|-------------------|

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

|                                 |                               |
|---------------------------------|-------------------------------|
| <u>3/4/75</u>                   | <u>507-11-5475</u>            |
| Date of birth                   | Social security number        |
| <u>97-181-1446</u>              | <u>manvel salvador fong</u>   |
| Driver's license number & state | Name as it appears on license |

**Report Copy:** If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: ☐.

Signature

Date

7/7/17

## EMERGENCY CONTACT INFORMATION

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

Employee Name: Manny Fong  
Address: 6452 Silver Mesa Dr  
Home Phone: 720-771-8327

| EMERGENCY CONTACTS                                                                        |                                                                       |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| Please list two people (in priority order) who could be contacted in case of an emergency |                                                                       |
| <b>Contact #1</b><br><br>Name: <u>Colleen Fong</u><br><br>Relationship: <u>Wife</u>       | Home Phone:<br><br>Cell Phone: <u>720-412-2647</u><br><br>Work Phone: |
| <b>Contact #2</b><br><br>Name: <u>Claudio Fong</u><br><br>Relationship:                   | Home Phone:<br><br>Cell Phone: <u>303-594-2348</u><br><br>Work Phone: |

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

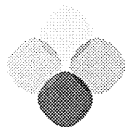
---

---

---

---

---



# employer solutions staffing group<sup>llc</sup>

Leveraging Resources in a Changing Market

## 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<br><u>Manvel S Fong</u> | SSN# (last 4 digits)<br><u>5475</u> | Effective Date |
|---------------------------------------|-------------------------------------|----------------|

### SECTION 2 PAYROLL ELECTION

☐ **Direct Deposit** (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated.*

☐ **Payroll Debit Card** (Please complete Sections 4 and 5 below)

### SECTION 3 DIRECT DEPOSIT

|         |                                                                                                                                  |                                                                                                                                                                                                                                                                         |
|---------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ACCOUNT | <input type="checkbox"/> Update Bank Account                                                                                     | <p><b>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.</b></p> <p>Initial _____ Date _____</p> |
|         | Bank Name:<br><u>Wells fargo</u>                                                                                                 |                                                                                                                                                                                                                                                                         |
|         | Routing#                                                                                                                         |                                                                                                                                                                                                                                                                         |
|         | Account#                                                                                                                         |                                                                                                                                                                                                                                                                         |
|         | Account Type: <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other _____ |                                                                                                                                                                                                                                                                         |

- To help us avoid making an error, please attach a copy of a voided check. **(a deposit slip will not work)**
- If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

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

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, 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                             | M.I.  | Last Name | Date of Birth       |
| Street Address (PO BOX NOT ACCEPTABLE) |       |           | Social Security#    |
| City                                   | State | Zip       | Cell Phone (mobile) |

#### RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)

|                                                  |                                       |
|--------------------------------------------------|---------------------------------------|
| Payroll Debit Card Routing #<br><b>073972181</b> | Payroll Debit Card Account #<br>_____ |
|--------------------------------------------------|---------------------------------------|

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

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

Date: \_\_\_\_\_

### SECTION 5 AUTHORIZATION

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

**\* E-mail is required for pay stub information.**

\*E-mail: hvskefong @ yahoo.com

*this information will only be used to send your paystubs electronically*

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

Date: 7/7/17

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

OMB No. 1545-1500

► Information about Form 8850 and its separate instructions is at [www.irs.gov/form8850](http://www.irs.gov/form8850).

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

Your name Manuel G. Long Social security number ► 507-11-5475  
Street address where you live 6452 Silver Mesa Dr #C  
City or town, state, and ZIP code Littleton CO 80130  
County Douglas Telephone number 720-771-8327  
If you are under age 40, enter your date of birth (month, day, year) \_\_\_\_\_

- 1 ☐ Check here if you received a conditional certification from the state workforce agency (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.
- 7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

## 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 ►

Date

**EMPLOYER SECTION:**

|                                            |                  |                          |
|--------------------------------------------|------------------|--------------------------|
| <b>Client:</b><br>Employer Solutions Group | <b>Company:</b>  |                          |
| <b>Location:</b>                           | <b>Position:</b> | <b>Starting Wage: \$</b> |

**EMPLOYEE SECTION:**

|                                      |                                                  |                                    |                                                                                                                        |
|--------------------------------------|--------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Employee Name:</b><br>Manuel Fung | <b>Street Address:</b><br>6452 Silver Mesa Dr #C | <b>City/State:</b><br>Littleton CO | <b>Zip:</b><br>80130                                                                                                   |
| <b>SS#:</b><br>507-11-5475           | <b>Date of Birth:</b><br>3/4/75                  | <b>Age:</b><br>42                  | <b>Have you worked for this company before?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| <b>If yes, location:</b>             |                                                  |                                    |                                                                                                                        |

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

Yes No

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                     |                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|
| <b>1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?</b> (If yes, please provide information below.)<br>Name of the person receiving benefits: _____ Relationship to you: _____<br>City: _____ County: _____ State: _____                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| <b>2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?</b> (If yes, please provide information below.)<br>Name of the person receiving benefits: _____ Relationship to you: _____<br>City: _____ County: _____ State: _____                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| <b>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?</b><br>Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits.<br><i>*If you checked yes please provide a copy of your SSI documentation.</i>                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| <b>4. Have you received any type of vocational rehabilitation services within the past two years?</b><br>If yes, please indicate which type of agency you worked with and provide their location information below:<br><input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program)<br>Name of Agency: _____ Phone #: _____<br>City: _____ County: _____ State: _____<br><i>*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</i> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| <b>5. Are you a Veteran of the U.S. Military?</b> <i>*If yes, please provide a copy of your DD-214 and letter of separation.</i><br>(If yes, please provide information below. If no, please continue to question #6.)<br>Dates of Service - From: <u>9/3/1993</u> To: <u>4/30/1996</u><br>Branch of Service: <u>VGMC</u><br><b>Are you entitled to or are you receiving compensation for a service-connected disability?</b>                                                                                                                                                                                        | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| <b>6. Have you been unemployed at any time during the last 12 months?</b><br>If yes, dates of unemployment - From: <u>6/12/17</u> To: <u>7/7/17</u><br><b>Did you receive unemployment compensation at any point during your unemployment?</b><br>If yes, dates received unemployment compensation - From: ____/____/____ To: ____/____/____                                                                                                                                                                                                                                                                         | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| <b>7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</b><br>Conviction Date: ____/____/____ Release Date: ____/____/____<br>Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____                                                                                                                                                                                                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| <b>Additional Tax Credits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                     |                                     |
| <b>IEC (Native American):</b> Are you or your spouse a member of a Native American Tribe?<br><i>*If you checked yes please provide a copy of your CDIB card.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/>            | <input type="checkbox"/>            |
| <b>CA Residents:</b> <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act?<br><input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?                                                                                                                                                                                                                                                                               |                                     |                                     |
| <b>SC Residents:</b> <input type="checkbox"/> Do you receive Family Independence Benefits?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                     |                                     |

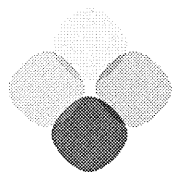
**PLEASE READ, SIGN, AND DATE:**

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

New Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

7/7/17



# employer solutions staffing group<sup>LLC</sup>

Leveraging Resources in a Changing Market

---

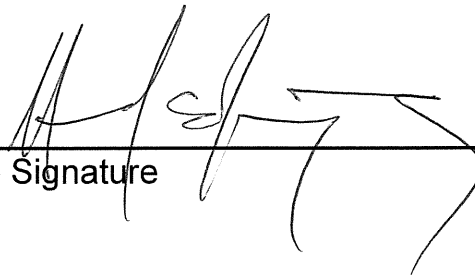
## STATEMENT OF CONFIDENTIALITY

This agreement made this 7 day of July, 2017, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Manny Long hereafter referred to as "employee".

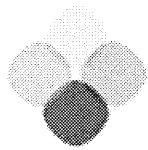
### **WITNESSETH:**

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



employer solutions staffing group  
Leveraging Resources in a Changing Market

# 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.

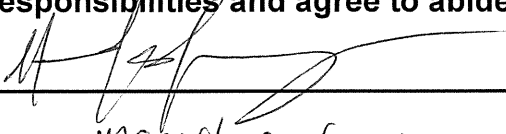
Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

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.

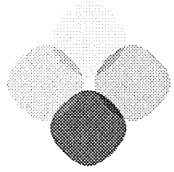
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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: Manuel S Fong



employer solutions staffing group<sup>LLC</sup>  
Leveraging Resources in a Changing Market

# Important/Importante

## LOST OR STOLEN PAYCHECKS

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

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the 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.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde):

manuel fong

Signature/Firma:

# DRUG AND ALCOHOL TESTING POLICY

## I. PURPOSE

Alcohol and drug abuse adversely affects job performance, the kind of work an employee performs and an employee's opportunities for successful employment. It is the intent of this document to provide employees with ESSG's [hereafter "the Company"] policy regarding the use of drugs and alcohol while at work. The Company does not intend to intrude into the private lives of its employees, but strongly believes that a drug-free workplace is in the best interest of employees and non-employees alike.

## II. SCOPE

This policy applies to all applicants for employment and to all employees including contract or temporary employees. The policy is applicable at Company facilities or whenever Company employees are performing company business.

## III. DISCLAIMER

Employment at the Company is at-will. This policy is not a unilateral employment contract and should not be interpreted as creating a unilateral employment contract.

## IV. PROHIBITIONS

A. No employee shall report to work under the influence of alcohol, any controlled substances, or any other drugs or medications that may affect the employee's alertness, coordination, reaction, response, judgment, decision-making, or safety.

B. No employee shall operate, use, or drive any equipment, machinery, or vehicle of the Company or any client of Company while under the influence of alcohol, any controlled substances, or any other drugs or medications that may adversely affect the employee's ability to operate such equipment, machinery, or vehicle. Employees are under an affirmative duty to immediately notify their supervisor if they are not in an appropriate mental or physical condition to operate, use, or drive any equipment machinery, or vehicle or otherwise safely perform their job duties.

C. No employee shall unlawfully manufacture, distribute, dispense, possess, transfer, or use a controlled substance in the workplace or wherever the Company's work is being performed.

D. Engaging in off-duty sale, purchase, transfer, use or possession of illegal drugs or controlled substances may have a negative effect on an employee's ability to perform his/her work for the Company. In such circumstances, the employee is subject to discipline.

E. When an employee is taking medically authorized drugs or other substances that may alter job performance, the employee is under an affirmative duty to notify their supervisor of the temporary inability to perform his or her job duties.

F. The Company shall notify the appropriate law enforcement agency, licensing boards, and other relevant authorities when it has reasonable suspicion to believe that an employee may have illegal drugs in his or her possession at work or on company premises.

G. Employees shall not consume alcoholic beverages during lunch periods, dinner periods, or breaks when returning immediately thereafter to perform work on behalf of the Company. In situations where the employee conducts the Company's business after the intake of alcohol, the employee shall be subject to discipline up to and including discharge.

## **V. ALCOHOL AND DRUG TESTING**

As part of the Company's commitment to an alcohol and drug-free workplace, the Company reserves the right to require that applicants and employees submit to drug or alcohol testing in accordance with the provisions of applicable law. This policy represents the notice required under applicable law and a copy will be provided to all applicants and employees who are requested to undergo testing. In the event of any conflict between this policy and applicable law in effect at the time of the test, the law will control.

### **A. Who May be Subject to Testing.**

1. Job Applicants. The Company may require that all applicants for a particular position be tested for drugs or alcohol after receiving a conditional offer of employment. If the applicant tests positive for drugs or alcohol, the conditional offer may be withdrawn.

2. Routine Physical Examination Testing. The Company may require employees to undergo a drug or alcohol test once a year as part of a routine physical examination. Affected employees will be given two weeks written notice that they will be tested for drugs or alcohol as part of a routine physical.

3. Random Testing. The Company may require employees in safety-sensitive positions to undergo testing on a random selection basis. Once the random selection has been made, the Company will not waive the selection of any employees identified through the random process.

4. Reasonable Suspicion Testing. The Company may require an employee to undergo drug or alcohol testing if the Company reasonably suspects that the employee:

- a. is under the influence of drugs or alcohol;
- b. has violated the Company's written work rules prohibiting drug and alcohol use;
- c. has sustained or caused another employee to sustain personal injury; or
- d. has caused a work-related accident or was operating or helping to operate machinery, equipment or vehicles involved in a work-related accident.

5. Treatment Program Testing. The Company may require an employee who has been referred for chemical dependency treatment or evaluation or is participating in a treatment program under an employee benefit plan to undergo drug or alcohol testing on a random basis and without advance notice during the evaluation or treatment period and for up to two years following the completion of any treatment program.

## **B. Conducting the Testing.**

1. Consent. All employees required to undergo testing will be required to complete and sign the employee consent form attached as Appendix A.

2. Refusal to Participate. An employee or job applicant has the right to refuse testing. However, a refusal of testing will be treated as a failure to comply with Company policy and may result in withdrawal of a job offer or disciplinary action up to and including termination of employment.

3. The Laboratory. The Company will use a laboratory certified by the National Institute on Drug Abuse (NIDA) or its successor, the College of American Pathologists (CAP), or the New York State Department of Health or other licensing body recognized by applicable law to perform all drug and alcohol tests.

### **4. Test Results.**

The laboratory will conduct both an initial test and a confirmatory test if the initial test is positive. A negative result on either the initial or confirmatory test will be deemed a negative test result (i.e. the employee passed the test). A positive result on both the initial and confirmatory test will be deemed a positive test result (i.e. the employee failed the test.)

a. Negative Test Result. An employee or applicant who tests negative for drugs or alcohol will be given written notice that they passed the test within three working days of the Company receiving the test results from the testing laboratory.

b. Positive Test Result. An employee or applicant who tests positive for drugs or alcohol will be given written notice that they have failed the test within three working days of the Company receiving the test results from the testing laboratory. The employee or applicant will then be given the opportunity to provide any information to explain the positive result, including any over-the-counter or prescription medications the employee or applicant may have taken. An employee or applicant who wishes to submit any explanatory information must do so within three working days after being notified of the positive test result.

An employee or applicant who has a positive test result may also request a retest of the original sample by the same or different certified laboratory at his or her own expense. An employee or applicant who wishes to conduct a retest must notify the Company in writing of their intention to conduct such a retest within five working days after being notified of the positive test result. If the results of the retest are negative, the test will be considered a negative test result.

C. Right to Test Result. An employee or job applicant has the right to request and receive from the Company a copy of the test result report on any drug or alcohol test.

C. Costs. All costs related to alcohol and drug testing will be paid by the Company, with the exception of any retests requested by the employee or applicant following a positive test result.

## **D. Disciplinary Action in Response to a Positive Test Result.**

1. Interim Discipline and Action: The Company reserves the right to temporarily suspend an employee or transfer the employee to another position at the same rate of pay pending the outcome of any drug or alcohol test. An employee who is suspended without pay will be reinstated with back pay if the test or any requested retest is negative.

2. Applicants. The Company reserves the right to withdraw the conditional job offer of any job applicant with a positive test result, without the opportunity to complete evaluation or treatment.

3. Employees - First Positive Test Result - Termination: The Company will not discharge an employee for the first positive test result. Instead the employee will be given the opportunity to participate in an appropriate drug or alcohol counseling or rehabilitation program as determined by a certified chemical use counselor or physician trained in the diagnosis and treatment of chemical dependency chosen by the Company. The employee will be responsible for paying all costs associated with any evaluation and subsequent treatment themselves or pursuant to coverage under an employee benefit plan. An employee who refuses or fails to participate in, cooperate with, or complete the evaluation or recommended treatment may be terminated. An employee who successfully completes treatment may be subject to random follow-up testing for a period of up to two years in accordance with section V.A.5. of this policy.

4. Employees - First Positive Test Result—Discipline: The Company reserves the right to take any other disciplinary action short of discharge it deems warranted following a first positive test result.

5. Employees-Subsequent Positive Test Result: An employee who has more than one positive test result may be terminated immediately following any second or subsequent positive test result without referral to or the opportunity to complete additional chemical dependency counseling or rehabilitation.

#### **E. Privacy of Test Results.**

1. Test results and other information acquired as a result of the testing program are private and confidential information and will not be disclosed by the Company or the testing laboratory to another employee or to third party individuals, government agencies, or private organizations without written consent of the employee or applicant being tested.

2. Evidence of a positive test result, however, may be used in an arbitration proceeding pursuant to a collective bargaining agreement, an administrative hearing, or a judicial proceeding, provided the information is relevant to the hearing or proceeding. Such evidence may also be disclosed to any federal agency or other unit of the United States government as required under federal law, regulation, or order. Evidence of a positive test result may also be disclosed to a substance abuse treatment facility for the purpose of evaluation or treatment.

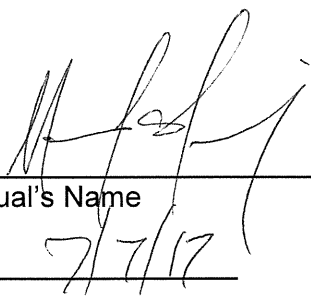
3. The Company will provide an employee with access to information in the employee's file relating to positive test result reports and other information acquired in the testing process as well as conclusions drawn from or actions taken based upon such information.

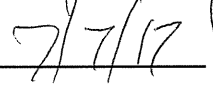
**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

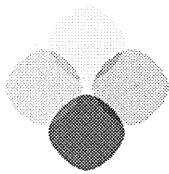
2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events 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.

  
\_\_\_\_\_  
Individual's Name

  
\_\_\_\_\_  
Date

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



employer solutions staffing group<sup>LLC</sup>

Leveraging Resources in a Changing Market

---

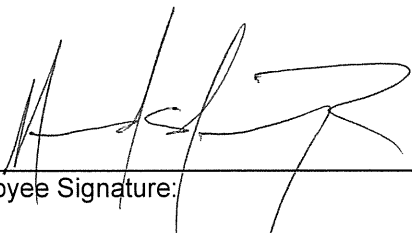
**Notification of Colorado Law Requirement –**  
**Unemployment Acknowledgement**

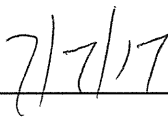
---

*According to Colorado Statutes section 8-73-105.3. A temporary employee who is given a notice that the employee is required to contact or notify the employer upon completion of an assignment and to be available to work, as agreed upon at the time of hire, during a specified period of time, on specified dates, or upon call by the employer on an as-needed basis and who does not contact or notify the employer upon completion of an assignment in compliance with the notice and is not available to work at the agreed-upon times is deemed to have voluntarily terminated employment for the purpose of determining benefits pursuant to section 8-73-108 (5) (e). Also, a temporary employee who agrees to work on an as-needed basis and refuses all work within three separate pay periods when contacted by the employer is deemed to have voluntarily terminated employment for reasons that may or may not allow an award of benefits pursuant to section 8-73-108.*

It is your responsibility to contact or notify ESSG (For example, by calling 303-920-1425, or using another means of contact) once your assignment ends. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact or notify ESSG once an assignment ends. I also acknowledge that I have received a separate copy of this form. \_\_\_\_\_ (Initial)

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

  
\_\_\_\_\_  
Date:

\_\_\_\_\_  
Employee (please print your name here)



## CONFIDENTIALITY & NONSOLICITATION AGREEMENT

This agreement made this 9th day of October, 2013 ("the Agreement"), is between Corporate Management Group Inc. ("CMG"), Employer Solutions Staffing Group LLC ("ESSG") **Colorado Lighting Inc.** ("the Company") and Manuel Forq ("Employee") (together "the Parties").

The Company is engaged in the business of Lighting and Electrical Distribution. The Company has employed Employee to perform services for it and Employee has accepted said employment.

In consideration of the foregoing and Employee's employment by the Company as good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

### 1. Confidentiality

- a. Definition of "Confidential Information." "Confidential Information" means all confidential business or financial information of the Company, including but not limited to any trade secrets, manufacturing plans, new product information, customer lists, or other information that is secret and of value.
- b. Employee's Use of Confidential Information. The Company owns certain trade secrets and confidential information in connection with its business, which are valuable assets of the Company. During the duration, and after the termination of this Agreement, Employee shall not, without the Company's prior written consent, directly or indirectly, use, disclose, or otherwise communicate any Confidential Information to any person or entity, except in performance of Employee's legitimate duties for the Company.
- c. Acknowledgment of Confidential Information. Employee acknowledges that Employee will have access to Confidential Information, made accessible to Employee only in strict confidence by the Company. Employee acknowledges that unauthorized disclosure will damage the Company's business and that Confidential Information could immediately be used by a competitor of the Company. The use and value of this Confidential Information depends on its continuing secrecy and the Company has taken appropriate steps to maintain this secrecy. Employee acknowledges that the restrictions contained in this section are reasonable and necessary for the protection of the Company's business.
- d. Definition of Company Property. Company Property is defined as, but not limited to, all documents or other records containing or reflecting Confidential Information prepared by or provided to Employee and all copies, in any medium, of such materials. Employee shall not copy or use any Company Property for any purpose not relating directly to Employee's work on the Company's behalf, or use, disclose, or sell any Company Property, except with the Company's prior written consent. Upon the termination of the employment relationship or upon the Company's request, Employee shall immediately deliver to the Company all Company Property. Employee may comply with any subpoena or court order, if Employee submits a copy of the subpoena or court order to the Company's President within three (3) working days of receipt.

- e. Entire Agreement. This agreement contains all of the terms agreed upon by the parties and supersedes all prior agreements, arrangements, and communications between the parties on this subject, whether oral or written.
- f. Survival. Employee's obligations under this agreement shall survive the termination of Employee's employment and shall be enforceable regardless of which party terminates the employment relationship and regardless of whether such termination is later claimed or found to be wrongful.
- g. Governing Law and Forum. All disputes or issues arising from this agreement or the Company's relationship with Employee shall be governed by the internal laws of the State of Colorado. Any action arising from or relating in any way to this agreement or Employee's employment with the Company shall be tried only in the state or federal courts situated in Colorado. The parties consent to jurisdiction and venue in those courts to the greatest extent possible under law.
- h. Severability. In the event any of the restrictions contained in this agreement are held to be unenforceable, the court so holding shall effect any change to the extent absolutely necessary to render the restrictions enforceable, while still maintaining the parties' expressed desire that the Company be protected to the greatest extent possible under the applicable law. Each of the terms and provisions of this agreement is severable in whole or in part, and any term or provision found to be invalid or illegal and unenforceable by the court shall be excised by the court, and the remaining terms and provisions shall not be affected and shall remain in full force and effect.
- i. Modification and Waiver. The parties agree that this agreement cannot be modified or waived without a written agreement signed by both parties. The Company's waiver of the breach of any provision of this agreement by Employee shall not constitute a waiver of any subsequent breach.
- j. Heirs and Assigns. This agreement shall be binding upon Employee's heirs, executors, administrators, or other legal representatives; shall inure to the benefit of the Company, its successors or assigns; and shall be freely assignable by the Company, but not by Employee.
- k. Headings. Numbers and titles to the sections of this agreement are for information purposes only and, where inconsistent with the text, are to be disregarded.
- l. Acknowledgment of Employee Opportunity to Seek Counsel. Employee has been afforded the opportunity to read, reflect upon, and consider the terms of the agreement; has been afforded the opportunity to discuss this agreement with an attorney or other adviser; and has read this entire agreement, fully understands its terms, and has voluntarily executed this agreement.
- m. **AT-WILL EMPLOYMENT. THE PARTIES ACKNOWLEDGE THAT THIS AGREEMENT SHALL NOT ALTER THE AT-WILL NATURE OF THEIR EMPLOYMENT RELATIONSHIP.**

DATED

7/7/17

EMPLOYEE

DATED:

CMG/ESSG REPRESENTATIVE

BY

TITLE



employer solutions staffing group<sup>LLP</sup>

Leveraging Resources in a Changing Market

## 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.



# employer solutions staffing group<sup>LLC</sup>

Leveraging Resources in a Changing Market

---

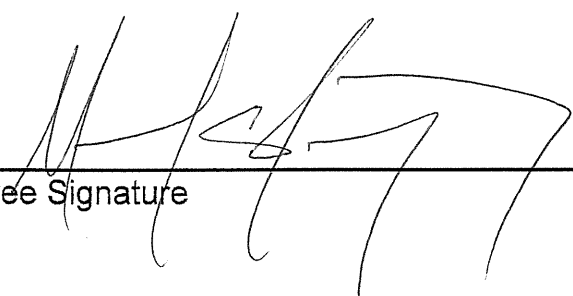
## STATEMENT OF CONFIDENTIALITY

This agreement made this 7 day of JULY, 2017, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and MARY FONG 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

Name: Manny Pong /DOH: 7/2/2017 PT/FT \_\_\_\_\_  
Phone: \_\_\_\_\_ CLIENT: Colorado Lighting DAY/NIGHT \_\_\_\_\_

NEW HIRE PAPERWORK:

OFFICE USE ONLY:

|                                     |                             |                                     |                         |
|-------------------------------------|-----------------------------|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | New Hire Application        | <input checked="" type="checkbox"/> | E-Verify                |
| <input checked="" type="checkbox"/> | W-4                         | <input checked="" type="checkbox"/> | Health Insurance        |
| <input checked="" type="checkbox"/> | Anti – Harassment           | <input checked="" type="checkbox"/> | Stop Payment Check Fee  |
| <input checked="" type="checkbox"/> | I-9                         | <input checked="" type="checkbox"/> | Direct Deposit Form     |
| <input checked="" type="checkbox"/> | Work Opportunity Tax Credit | <input checked="" type="checkbox"/> | Emergency Contact       |
| <input checked="" type="checkbox"/> | 8850 Pre Screen             | <input checked="" type="checkbox"/> | Background Release Form |
| <input checked="" type="checkbox"/> | Copy of I-9 documentation   | <input checked="" type="checkbox"/> | Non-Compete             |