



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 Salah First Name Mohamed Middle Initial A
Street Address 427 33rd AV NW Apt/Ste 104
City/State/Zip St Cloud MN 56303 Social Security Last Four XXX-XX-3912
Phone Number 320-714-5165 Email Address _____ @ _____
Staffing Agency/Recruitment Partner CMO-BH

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.

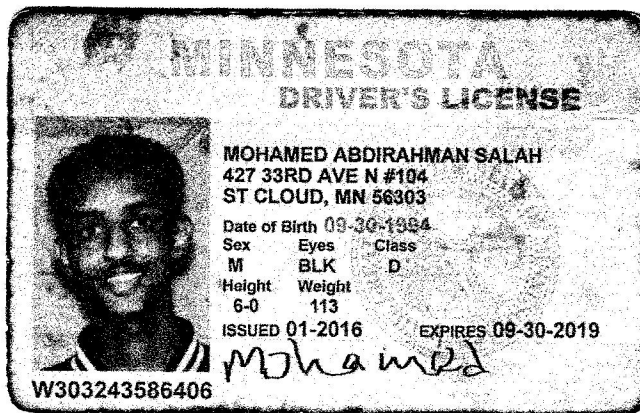
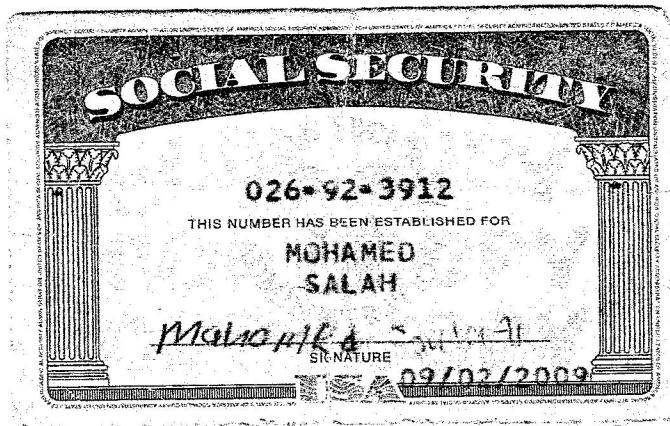
Mohamed Salah
Name (Print or type)

[Signature]
Applicant's Signature

5/4/2017
Date

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

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





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) Salah		First Name (Given Name) Mohamed		Middle Initial A	Other Last Names Used (if any) N/A
Address (Street Number and Name) 427-rd Avenue North		Apt. Number 104	City or Town St. Cloud		State MN ZIP Code 56303
Date of Birth (mm/dd/yyyy) 09/30/1994	U.S. Social Security Number 0 2 6 - 9 2 - 3 9 1 2		Employee's E-mail Address N/A		Employee's Telephone Number (320) 774-5165

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):

☐ 1. A citizen of the United States
☐ 2. A noncitizen national of the United States (See instructions)
☒ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): 212294192
☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): N/A Some aliens may write "N/A" in the expiration date field. (See instructions)
Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.
1. Alien Registration Number/USCIS Number: N/A OR
2. Form I-94 Admission Number: N/A OR
3. Foreign Passport Number: N/A Country of Issuance: N/A

QR Code - Section 1
Do Not Write In This Space



Signature of Employee Mohamed Salah	Today's Date (mm/dd/yyyy) 05/05/2017
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Preparer and/or Translator Certification (check one):

☒ I did not use a preparer or translator.	☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
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(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		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





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) Salah	First Name (Given Name) Mohamed	M.I. A	Citizenship/Immigration Status 3
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title N/A		Document Title Driver's license issued by state/territory		Document Title Social Security Card (Unrestricted)
Issuing Authority N/A		Issuing Authority Minnesota		Issuing Authority Social Security Administration
Document Number N/A		Document Number W303243586406		Document Number 026923912
Expiration Date (if any)(mm/dd/yyyy) N/A		Expiration Date (if any)(mm/dd/yyyy) 09/30/2019		Expiration Date (if any)(mm/dd/yyyy) N/A
Document Title N/A		Additional Information QR Code - Section 2 Do Not Write In This Space 		
Issuing Authority N/A				
Document Number N/A				
Expiration Date (if any)(mm/dd/yyyy) N/A				
Document Title N/A				
Issuing Authority N/A				
Document Number N/A				
Expiration Date (if any)(mm/dd/yyyy) N/A				

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): 05/05/2017 (See instructions for exemptions)

Signature of Employer or Authorized Representative <i>Lori Larson</i>		Today's Date(mm/dd/yyyy) 05/05/2017	Title of Employer or Authorized Representative On-Site representative	
Last Name of Employer or Authorized Representative Larson	First Name of Employer or Authorized Representative Lori	Employer's Business or Organization Name Employer Solutions Group, LLC		
Employer's Business or Organization Address (Street Number and Name) 7480 Flying Cloud Drive Suite 200		City or Town Minneapolis	State MN	ZIP Code 55344

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

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

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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employer solutions staffing group^{llc}

Leveraging Resources in a Changing Market

Wage Payment Method Authorization (Minnesota)

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 paper Check.

SECTION 1 BASIC INFORMATION

Employee Name Mohamed Salah SSN# (last 4 digits) 3912 Effective Date 5-8-17

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) ☒ Paper Check (Please complete Section 5 below)

SECTION 3 DIRECT DEPOSIT

☐ Update Bank Account
Bank Name: _____
Routing# _____
Account# _____
Account Type: ☐ Checking ☐ Savings ☐ Other _____

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

Initial _____ Date _____

- 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 # 073972181 Payroll Debit Card Account # _____

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

Employee's Signature: _____ Date: _____

SECTION 5 AUTHORIZATION

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

* E-mail is required for pay stub information.

*E-mail: _____ @ _____
this information will only be used to send your paystubs electronically

Employee's Signature: Mohamed Salah Date: _____

EMERGENCY CONTACT INFORMATION

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

Employee Name: Mohamed Salah

Address: 427 33rd Av W

Home Phone: 320-251-3912

EMERGENCY CONTACTS

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

Contact #1

Name: Barni AL

Relationship: Wife

Home Phone:

Cell Phone: 320-224-6482

Work Phone:

Contact #2

Name: Yussuf Kassim

Relationship:

Home Phone:

Cell Phone: 413-271-6791

Work Phone:

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

ENROLLMENT FORM

ESC/MEC ES P4DM v18.2

A. REQUIRED EMPLOYEE INFORMATION

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

Name <u>Mohamed Salah</u>	Home Phone <u>320-774-5165</u>	
Social Security # <u>026-92-3912</u>	Date of Birth <u>09/30/1994</u>	Sex ☒ M ☐ F
Address <u>427 33rd Ave W</u>	Apt. # <u>104</u>	
City <u>St Cloud MN</u>	Zip <u>56303</u>	State <u>MN</u>

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare benefits?

☐ Yes ☒ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):

1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. This plan is underwritten by BCS Insurance Company.

FIXED INDEMNITY MEDICAL ¹

DENTAL

VISION

TERM LIFE

SHORT-TERM DISABILITY ²

Employee Only	☐ \$38.56	☒ \$5.40	☒ \$2.42	☒ \$0.60	☒ \$4.20
Employee + 1	☐ \$78.25	☐ \$10.80	☐ \$4.92	☐ \$0.90	☐
Employee + Family	☐ \$104.49	☐ \$17.82	☐ \$6.56	☐ \$1.80	☐
☒ NO to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

¹ This coverage is not available to residents of NH, HI, or PR. ² STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Name <u>M</u>	Social Security #	Date of Birth / /	Sex ☒ M ☐ F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex ☒ M ☐ F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Sex ☒ M ☐ F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

2219000-M-CMGa Direct Payment Monthly Rates

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. This plan satisfies the federal healthcare reform Individual Mandate. This is an offer of ACA compliant coverage and by purchasing this plan, you will not be taxed for failing to purchase insurance required by the Affordable Care Act. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ \$62.00 Employee Only ☐ \$69.02 Employee + 1 ☐ \$73.67 Employee + Family ☒ NO to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage.

DATE 05/05/2017SIGNATURE Mohamed

Authorization

Authorization: By signing below, you authorize: (a) backgroundchecks.com ("BGC") and/or Orange Tree Employment Screening to request information about you from any public or private information source; (b) anyone to provide information about you to BGC and/or Orange Tree Employment Screening; (c) BGC and/or Orange Tree Employment Screening to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) Employer Solutions Staffing Group, LLC ("ESSG") to share those reports with others for legitimate business purposes related to your employment. BGC and/or Orange Tree Employment Screening 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 employee of ESSG.

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: mohamed A salah
First Middle (☐ none) Last

Other names used: _____

Current county of residence: _____

Current and former addresses:

	current		
from Mo/Yr	to Mo/Yr	Street	City, State & Zip

from Mo/Yr	to Mo/Yr	Street	City, State & Zip
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from Mo/Yr	to Mo/Yr	Street	City, State & Zip
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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>09/30/1994</u> Date of birth	<u>026-9813912</u> Social security number
<u>W303247586403</u> Driver's license number & state	<u>mohamed s</u> 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]
Signature

5/2/17
Date

done

**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.

Mohamed

Individual's Name

05/4/2014

Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6

Acknowledgement of Receipt Antiharassment Policy

I certify that I have received a copy of Employer Solutions Staffing Group's Antiharassment Policy. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at **952.835.1288/1.866.496.7573** with any questions I may have about this policy. I agree to comply with ESSG's policy on Antiharassment and understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am involved in any employment dispute or I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, marital, sexual orientation or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact my supervisor, manager, director or ESSG's Human Resource Department at **952.835.1288/1.866.496.7573** in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Mohamed Salah

Employee's Signature:

[Signature] Date: 5/4/17

RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT

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

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

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

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

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

DATE 5/4/2017

EMPLOYEE
NAME mohamed salah
PLEASE PRINT

EMPLOYEE
SIGNATURE [Signature]

ESSG
REPRESENTATIVE Lou Harrison



ACKNOWLEDGMENT

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

1. This handbook is intended as a guide and **not** an employment agreement that creates a contractual relationship, and that the employment relationship may be terminated at the will of either party at any time.
2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.
3. I agree to **notify** my CMG/ESSG Consultant **immediately** of any change in my personal data such as phone number, address, emergency notification, etc.
4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my CMG/ESSG Consultant.

Date:

5/4/07

Associate's Signature:

Amel

Associate's Printed Name:

Amel Mohamed Salah

Orientation provided by:

Lori Hanson

STATEMENT OF CONFIDENTIALITY

This agreement made this 5th day of July, 2017, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Mohamed Salah hereafter referred to as "employee".

WITNESSETH:

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

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


Employee Signature


Employer Solutions Staffing Group LLC, Representative

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

OMB No. 1545-1500

► Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

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

Your name Mohame Salah Social security number ► 026-042-3912
Street address where you live 427 33rd Av W
City or town, state, and ZIP code St Cloud MN 56303
County Stearns county Telephone number 320-774-5165
If you are under age 40, enter your date of birth (month, day, year) 09-30-1994

- 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 ► [Signature]

Date

5/4/2014

EMPLOYER SECTION:

Client: Employer Solutions Group	Company:	
Location:	Position:	Starting Wage: \$

EMPLOYEE SECTION:

Employee Name: Mohamed Salah		Street Address:		City/State:	Zip:
SS#: 026-92-3912	Date of Birth: 09/30/1994	Age: 22	Have you worked for this company before? ☒ Yes ☐ No	If yes, location:	

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

Yes No

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

PLEASE READ, SIGN, AND DATE:

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

New Employee Signature: _____

Date: 5/4/2017

Qualified Long-Term Unemployment Recipient

ADDENDUM TO: IRS Form 8850 Pre-Screening Notice and Certification Request for the Work Opportunity Tax Credit

Client: Employer Solutions Group	Company:	
Location:	Employee Name: Mohamed Salah	SS#: 026-92-3912

EMPLOYEE:

Please check the statement(s) that apply to you and sign where indicated below.

- ☐ I have been unemployed at any time during the last 12 months.

If applicable, dates of unemployment - From: _____ To: _____
From: ____/____/____ To: ____/____/____
From: ____/____/____ To: ____/____/____

- ☐ I received unemployment compensation during my unemployment.

If applicable, dates you received compensation - From: _____ To: _____
From: ____/____/____ To: ____/____/____
From: ____/____/____ To: ____/____/____

Please read, sign, and date:

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

Employee Signature: <i>M. Salah</i>	Date: 5/4/2017
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RetroTax[®]
3730 Washington Blvd.
Indianapolis, IN 46205
317-925-0553
wotc@retrotax-aci.com
www.retrotax-aci.com



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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: Mohamed

Printed Name: Mohamed Salah



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Important/Importante

LOST OR STOLEN PAYCHECKS

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

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

CHEQUES DE PAGO PERDIDOS O ROBADOS

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

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

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): mohamed salah

Signature/Firma: 



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Acknowledgement of Receipt of Workplace Safety Policy

I certify that I have received a copy of Employer Solutions Staffing Group's ESSG WORKPLACE SAFETY POLICY. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at 952.835.1288/1.866.496.7573 with any questions I may have about this policy. I agree to comply with ESSG's policy on ESSG WORKPLACE SAFETY POLICY and I understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am believe that I am working in an unsafe or dangerous work environment, I will immediately contact my supervisor, manager, director or ESSG's Safety Director at 952.835.1288/1.866.496.7573 in order to obtain assistance in the resolution of such matters.

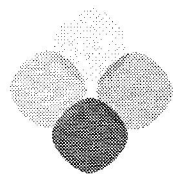
Employee Name (Please Print)

Mohamed Salah

Employee's Signature:

[Signature]

Date: 5/4/2017



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Notification of Minnesota Law Requirement –
Unemployment Acknowledgement

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

It is your responsibility to contact ESSG (for instance, by calling (320) 281.5617 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

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

[Handwritten Signature]

Employee Signature:

5/4/2017

Date:

mohamed salah

Employee (please print your name here)