

employer solutions staffing group

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Harrell First Name Noah Middle Initial D
 Street Address 827 Elm St #2 Apt/Ste 2
 City/State/Zip Fort Collins, CO, 80521 Social Security Last Four XXX-XX-3248
 Phone Number (913)470-0282 Email Address Harrelln90@gmail.com
 Staffing Agency/Recruitment Partner CMG

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.

Noah D Harrell [Signature] 08/31/17
 Name (Print or type) Applicant's Signature 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 _____	

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.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u>1</u>
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B	<u>1</u>
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u> </u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F	<u> </u>
(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)			
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.		
• If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children.			
• 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. G			
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶ H	<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.

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2017	
▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.					
1 Your first name and middle initial <u>Noah D.</u>		Last name <u>Harrell</u>		2 Your social security number <u>297-83-3788</u>	
Home address (number and street or rural route) <u>827 Elm #2</u>		3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.			
City or town, state, and ZIP code <u>Fort Collins, CO, 80521</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. ▶ ☐			
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	<u>\$0.00</u>
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ <u>7</u>					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶ <u>[Signature]</u>				Date ▶ <u>08/31/17</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)



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

Affirmation of Legal Work Status

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

a Employee Name: Harrell Noah Dees 04/05/1990
Last First Middle Date of Birth

c Social Security Number: 292-43-3246 Date of Hire: 04/31/2017 (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)

09/08/2017 (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.



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) <u>Harrell</u>		First Name (Given Name) <u>Noah</u>		Middle Initial <u>Dees</u>	Other Last Names Used (if any)	
Address (Street Number and Name) <u>622 Elm #2</u>		Apt. Number <u>2</u>	City or Town <u>Fort Collins</u>		State <u>CO</u>	ZIP Code <u>80521</u>
Date of Birth (mm/dd/yyyy) <u>09/05/1990</u>	U.S. Social Security Number <u>242-83-3248</u>	Employee's E-mail Address <u>Harrelln90@gmail.com</u>			Employee's Telephone Number <u>(513) 970-0287</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):

☒ 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): _____	
☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): <u>N/A</u> 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: <u>N/A</u> OR 2. Form I-94 Admission Number: <u>N/A</u> OR 3. Foreign Passport Number: <u>N/A</u> Country of Issuance: <u>N/A</u>	QR Code - Section 1 Do Not Write In This Space

Signature of Employee <u>[Signature]</u>	Today's Date (mm/dd/yyyy) <u>08/31/2017</u>
---	--

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.
(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) <u>Harrell</u>	First Name (Given Name) <u>Noah</u>	M.I. <u>D</u>	Citizenship/Immigration Status <u>US Citizen</u>
------------------------------	---	--	------------------	---

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title <u>US Passport</u>		Document Title		Document Title
Issuing Authority <u>US Dept. of State</u>		Issuing Authority		Issuing Authority
Document Number <u>451291882</u>		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy) <u>01/13/2019</u>		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information QR Code - Sections 2 & 3 Do Not Write In This Space		
Issuing Authority				
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): 09/05/2017 (See instructions for exemptions)

Signature of Employer or Authorized Representative <u>Andrea Findley</u>	Today's Date (mm/dd/yyyy) <u>09/08/2017</u>	Title of Employer or Authorized Representative <u>Executive Assistant</u>	
Last Name of Employer or Authorized Representative <u>Findley</u>	First Name of Employer or Authorized Representative <u>Andrea</u>	Employer's Business or Organization Name <u>EMPLOYER SOLUTIONS STAFFING GROUP LLC</u>	
Employer's Business or Organization Address (Street Number and Name) <u>7480 FLYING CLOUD DRIVE SUITE 200</u>		City or Town <u>EDEN PRAIRIE</u>	State <u>MN</u>
			ZIP Code <u>55344</u>

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)
----------------	-----------------	---------------------------------------

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
--	---------------------------	---

1470

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

371

372

373

374

375

376

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392

393

394

395

396

397

398

399

400

401

402

403

404

405

406

407

408

409

410

411

412

413

414

415

416

417

418

419

420

421

422

423

424

425

426

427

428

429

430

431

432

433

434

435

436

437

438

439

440

441

442

443

444

445

446

447

448

449

450

451

452

453

454

455

456

457

458

459

460

461

462

463

464

465

466

467

468

469

470

471

472

473

474

475

476

477

478

479

480

481

482

483

484

485

486

487

488

489

490

491

492

493

494

495

496

497

498

499

500

501

502

503

504

505

506

507

508

509

510

511

512

513

514

515

516

517

518

519

520

521

522

523

524

525

526

527

528

529

530

531

532

533

534

535

536

537

538

539

540

541

542

543

544

545

546

547

548

549

550

551

552

553

554

555

556

557

558

559

560

561

562

563

564

565

566

567

568

569

570

571

572

573

574

575

576

577

578

579

580

581

582

583

584

585

586

587

588

589

590

591

592

593

594

595

596

597

598

599

600

601

602

603

604

605

606

607

608

609

610

611

612

613

614

615

616

617

618

619

620

621

622

623

624

625

626

627

628

629

630

631

632

633

634

635

636

637

638

639

640

641

642

643

644

645

646

647

648

649

650

651

652

653

654

655

656

657

658

659

660

661

662

663

664

665

666

667

668

669

670

671

672

673

674

675

676

677

678

679

680

681

682

683

684

685

686

687

688

689

690

691

692

693

694

695

696

697

698

699

700

701

702

703

704

705

706

707

708

709

710

711

712

713

714

715

716

717

718

719

720

721

722

723

724

725

726

727

728

729

730

731

732

733

734

735

736

737

738

739

740

741

742

743

744

745

746

747

748

749

750

751

752

753

754

755

756

757

758

759

760

761

762

763

764

765

766

767

768

769

770

771

772

773

774

775

776

777

778

779

780

781

782

783

784

785

786

787

788

789

790

791

792

793

794

795

796

797

798

799

800

801

802

803

804

805

806

807

808

809

810

811

812

813

814

815

816

817

818

819

820

821

822

823

824

825

826

827

828

829

830

831

832

833

834

835

836

837

838

839

840

841

842

843

844

845

846

847

848

849

850

851

852

853

854

855

856

857

858

859

860

861

862

863

864

865

866

867

868

869

870

871

872

873

874

875

876

877

878

879

880

881

882

883

884

885

886

887

888

889

890

891

892

893

894

895

896

897

898

899

900

901

902

903

904

905

906

907

908

909

910

911

912

913

914

915

916

917

918

919

920

921

922

923

924

925

926

927

928

929

930

931

932

933

934

935

936

937

938

939

940

941

942

943

944

945

946

947

948

949

950

951

952

953

954

955

956

957

958

959

960

961

962

963

964

965

966

967

968

969

970

971

972

973

974

975

976

977

978

979

980

981

982

983

984

985

986

987

988

989

990

991

992

993

994

995

996

997

998

999

1000

1001

1002

1003

1004

1005

1006

1007

1008

1009

1010

1011

1012

1013

1014

1015

1016

1017

1018

1019

1020

1021

1022

1023

1024

1025

1026

1027

1028

1029

1030

1031

1032

1033

1034

1035

1036

1037

1038

1039

1040

1041

1042

1043

1044

1045

1046

1047

1048

1049

1050

1051

1052

1053

1054

1055

1056

1057

1058

1059

1060

1061

1062

1063

1064

1065

1066

1067

1068

1069

1070

1071

1072

1073

1074

1075

1076

1077

1078

1079

1080

1081

1082

1083

1084

1085

1086

1087

1088

1089

1090

1091

1092

1093

1094

1095

1096

1097

1098

1099

1100

1101

1102

1103

1104

1105

1106

1107

1108

1109

1110

1111

1112

1113

1114

1115

1116

1117

1118

1119

1120

1121

1122

1123

1124

1125

1126

1127

1128

1129

1130

1131

1132

1133

1134

1135

1136

1137

1138

1139

1140

1141

1142

1143

1144

1145

1146

1147

1148

1149

1150

1151

1152

1153

1154

1155

1156

1157

1158

1159

1160

1161

1162

1163

1164

1165

1166

1167

1168

1169

1170

1171

1172

1173

1174

1175

1176

1177

1178

1179

1180

1181

1182

1183

1184

1185

1186

1187

1188

1189

1190

1191

1192

1193

1194

1195

1196

1197

1198

1199

1200

1201

1202

1203

1204

1205

1206

1207

1208

1209

1210

1211

1212

1213

1214

1215

1216

1217

1218

1219

1220

1221

1222

1223

1224

1225

1226

1227

1228

1229

1230

1231

1232

1233

1234

1235

1236

1237

1238

1239

1240

1241

1242

1243

1244

1245

1246

1247

1248

1249

1250

1251

1252

1253

1254

1255

1256

1257

1258

1259

1260

1261

1262

1263

1264

1265

1266

1267

1268

1269

1270

1271

1272

1273

1274

1275

1276

1277

1278

1279

1280

1281

1282

1283

1284

1285

1286

1287

1288

1289

1290

1291

1292

1293

1294

1295

1296

1297

1298

1299

1300

1301

1302

1303

1304

1305

1306

1307

1308

1309

1310

1311

1312

1313

1314

1315

1316

1317

1318

1319

1320

1321

1322

1323

1324

1325

1326

1327

1328

1329

1330

1331

1332

1333

1334

1335

1336

1337

1338

1339

1340

1341

1342

1343

1344

1345

1346

1347

1348

1349

1350

1351

1352

1353

1354

1355

1356

1357

1358

1359

1360

1361

1362

1363

1364

1365

1366

1367

1368

1369

1370

1371

1372

1373

1374

1375

1376

1377

1378

1379

1380

1381

1382

1383

1384

1385

1386

1387

1388

1389

1390

1391

1392

1393

1394

1395

1396

1397

1398

1399

1400

1401

1402

1403

1404

1405

1406

1407

1408

1409

1410

1411

1412

1413

1414

1415

1416

1417

1418

1419

1420

1421

1422

1423

1424

1425

1426

1427

1428

1429

1430

1431

1432

1433

1434

1435

1436

1437

1438

1439

1440

1441

1442

1443

1444

1445

1446

1447

1448

1449

1450

1451

1452

1453

1454

1455

1456

1457

1458

1459

1460

1461

1462

1463

1464

1465

1466

1467

1468

1469

1470

1471

1472

1473

1474

1475

1476

1477

1478

1479

1480

1481

1482

1483

1484

1485

1486

1487

1488

1489

1490

1491

1492

1493

1494

1495

1496

1497

1498

1499

1500

1501

1502

1503

1504

1505



SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2017251113546ZV

Report Prepared: 09/08/2017

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Harrell

First Name: Noah

Date of Birth: 04/05/1990

Social Security Number: *** ** 3788

Hire Date: 09/05/2017

Citizenship Status: A citizen of the United States

Document Information

List A Document: U.S. Passport or Passport Card

Passport or Passport Card Number: 451291882

Document Expiration Date: 01/13/2019

Case Status Information

Final Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 09/08/2017

Case Submitted By: AFIN3846

Closed On: 09/08/2017

Closed By: AFIN3846

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

SENSITIVE BUT UNCLASSIFIED

EMPLOYER SOLUTIONS STAFFING GROUP
BACKGROUND CHECK AUTHORIZATION

Employee Name: Noah D Harrell
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

* Current Address Since: 8/2017 827 ELM #2 Fort Collins CO 80521
(Mo/Yr) (Street) (City) (State/Zip)

* Previous Address From: 06/2017 101 N 4th St Ripley OH 43167
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: _____
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: 242-83-3268 DOB: 09/04/1990

Phone Number: (513) 470-0282

Driver's License Number/State: TE333298 OH

The information contained in this application is correct to the best of my knowledge.

I hereby authorize Employer Solutions Staffing Group, LLC and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to Employer Solutions Staffing Group, LLC or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Employer Solutions Staffing Group, LLC and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: Noah D Harrell Date: 08/31/17

Notice to CA, MN, and OK Residents:

Please check the box below if you wish to receive a copy of a consumer report that is requested.

☐ I wish to receive a copy of any Background Check Report on me that is requested.

EMERGENCY CONTACT INFORMATION

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

Employee Name: Noah D. Harrell
Address: 627 Elm #2 Fort Collins, CO 80521
Home Phone: (913) 470-0287

EMERGENCY CONTACTS

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

Contact #1 Name: <u>Leanna Defere</u> Relationship: <u>Girlfriend</u>	Home Phone: Cell Phone: <u>(719) 393-2647</u> Work Phone:
Contact #2 Name: <u>Linda Douglas</u> Relationship: <u>Mother</u>	Home Phone: Cell Phone: <u>(913) 207-2660</u> Work Phone: <u>(937) 392-4389</u>

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

Allergic to Sulfur drugs



7055 East Evans Ave. . Denver, CO 80224 . (303) 691-2345

PAYROLL DEDUCTION OR DIRECT DEPOSIT FORM
~~~~~

Date: 08/30/17

To: PAYROLL DEPARTMENT

From: Public Service Credit Union (Depository Institution)  
ABA # 302075830

Our member Noah D Harrell has requested that they be set up for direct deposit. This form is to help assist in giving you the correct ABA and member account number for our institution.

Our member has chosen the following account for the direct deposit.

Checking 0100268408

IF YOU HAVE ANY QUESTIONS, PLEASE CALL MEMBER SERVICE AT 303-691-2345  
OR WRITE US AT 7055 EAST EVANS, DENVER, CO 80224 OR YOU CAN CALL  
Noah D Harrell AT .

Emp creating form: 3,979



employer solutions staffing group...

## 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 Noah D. Harrell SSN# (last 4 digits) 242-83-3748 Effective Date 08/31/17

### 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)

### SECTION 3 DIRECT DEPOSIT

|         |                                                                                                                       |                                                                                                                                                                                                                                                                                |
|---------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ACCOUNT | <input type="checkbox"/> Update Bank Account                                                                          | <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><br><br>Initial <u>NH</u> Date <u>08/31/17</u> |
|         | Bank Name: <u>Public Service Credit Union</u>                                                                         |                                                                                                                                                                                                                                                                                |
|         | Routing# <u>302075830</u>                                                                                             |                                                                                                                                                                                                                                                                                |
|         | Account# <u>0100268408</u>                                                                                            |                                                                                                                                                                                                                                                                                |
|         | Account Type: <input 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 # |
|--------------------------------------------------|------------------------------|

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: \_\_\_\_\_

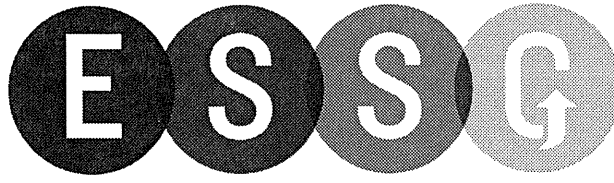
### SECTION 5 AUTHORIZATION

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: HarrellN98@gmail.com  
this information will only be used to send your paystubs electronically

Employee's Signature: Noah Harrell Date: 08/31/17



employer solutions staffing group<sub>llc</sub>

---

**STATEMENT OF CONFIDENTIALITY**

This agreement made this 31 day of August, 2017, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Noah D. Harrell hereafter referred to as "employee".

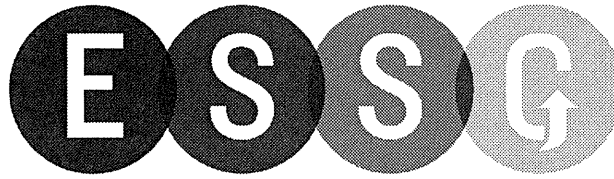
**WITNESSETH:**

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<sup>llc</sup>

## 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.

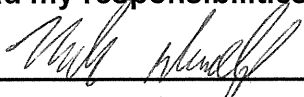
Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

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.

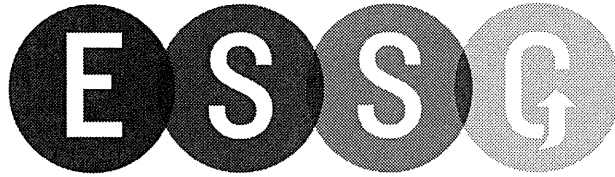
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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: Nady Harrell



employer solutions staffing group<sub>llc</sub>

## 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

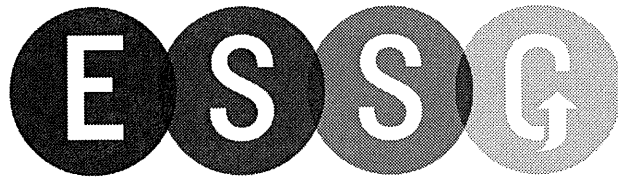
Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, 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): Noah Harrell

Signature/Firma: 



employer solutions staffing group<sub>inc</sub>

## **ESSG WORKPLACE SAFETY POLICY**

It is ESSG's policy that all employees should be able to enjoy a hazard free and safe work environment. It is ESSG's duty to:

- (1) Ensure that its clients provide you with a workplace free from serious recognized hazards and comply with standards, rules and regulations issued under the OSH Act.
- (2) Ensure that its clients perform a job hazard assessment in order to identify and eliminate potential safety and health hazards and to determine necessary training and protections for employees at the facility.
- (3) Make sure employees have and use safe tools and equipment.
- (4) Establish or update operating procedures and communicate them so that employees follow safety and health requirements.
- (5) Provide safety training in a language and vocabulary workers can understand.

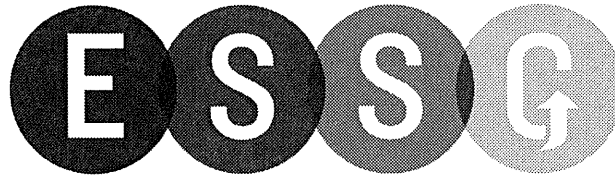
ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

To help ensure a safe workplace, you have certain responsibilities too, which include the following:

- Responsibility to work in compliance with OSHA laws and regulations
- Responsibility to use personal protective equipment and clothing as directed by the host employer
- Responsibility to report workplace hazards and dangers
- Responsibility to work in a manner as required by the employer and use the prescribed safety equipment.

You have the following basic rights:

- Right to refuse unsafe work
- Right to know or be informed about actual and potential dangers in the workplace
- Right to review copies of appropriate standards, rules, regulations and requirements that the host employer is required to have available at the workplace.



employer solutions staffing group<sub>llc</sub>

### 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)

Noah D. Harrell

Employee's Signature:

 Date: 08/31/17

**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 Noah D. Harrell Social security number ► 242-63-3746  
Street address where you live 422 Elm St #2  
City or town, state, and ZIP code Fort Collins CO 80521  
County Lebanon Telephone number (913) 470-0267  
If you are under age 40, enter your date of birth (month, day, year) 09/09/2012

- 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

09/31/17

## EMPLOYER SECTION:

|           |           |                   |
|-----------|-----------|-------------------|
| Client:   | Company:  |                   |
| Location: | Position: | Starting Wage: \$ |

## EMPLOYEE SECTION:

|                        |                |                 |                                                                     |                   |
|------------------------|----------------|-----------------|---------------------------------------------------------------------|-------------------|
| First Name: Last Name: | Suffix:        | Street Address: | City/State:                                                         | Zip:              |
| Noah Halliell          |                | 822 Elm St #2   | Fort Collins, CO                                                    | 90521             |
| SS#:                   | Date of Birth: | Age:            | Have you worked for this company before?                            | If yes, location: |
| 247-83-3288            | 04/09/1990     | 27              | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                   |

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: _____ To: _____<br>Branch of Service: _____<br><b>Are you entitled to or are you receiving compensation for a service-connected disability?</b>                                                                                                                                                                                                                   | <input type="checkbox"/>            | <input checked="" 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>01/12</u> To: <u>04/17</u><br><b>Did you receive unemployment compensation at any point during your unemployment?</b><br>If yes, in which state did you receive unemployment compensation? _____                                                                                                                                                                                                                                                                                               | <input checked="" type="checkbox"/> | <input checked="" 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 checked="" 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: 04/31/17



**LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM**  
**Work Opportunity Tax Credit (WOTC) Program**

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

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

9 New Hire's Signature: Myk Mull Date 08/31/17

6 New Hire Name: Noah Deer Harrell

Social Security Number:

Employer Name: \_\_\_\_\_

**Please check the statements below if they apply to you.**

☐ I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

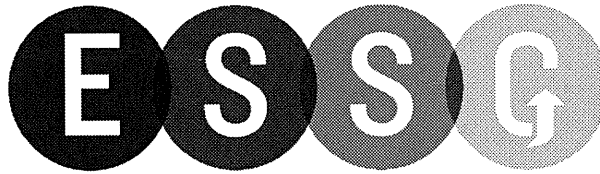
☐ I declare that I have been in a period of unemployment since \_\_\_\_\_.  
(Enter start date)

**Privacy Act Notice:**

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

**Public Burden Statement:**

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.



employer solutions staffing group, LLC

---

## **Notification of 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. NA (Initial)

Employee Signature:

04/30/17

Date:

Mark Harrell

Employee (please print your name here)

# 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

**DO NOT SIGN THIS PAGE—SIGN IDENTICAL PAGE AT END OF MANUAL**

**DRUG AND ALCOHOL  
TESTING CONSENT FORM**

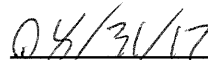
1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

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**



### Drug Screening Test Results

#### Company Information

Company Name: Corporate Management Group

Address: 12000 N. Washington St, Suite 350, Thornton, CO 80241

Name of Collector: Lauren Kenney

#### Donor Information

Donor First & Last Name: of NOAH HARRELL

Reason for Test: Pre-employment Screening

#### Screen Results

Date Collected: 8/31/17

| Test                  | Pass | Fail |
|-----------------------|------|------|
| Cocaine (COC)         | X    |      |
| Marijuana (THC)       | X    |      |
| Opiate (OPI)          | X    |      |
| Amphetamine (AMP)     | X    |      |
| Methamphetamine (MET) | X    |      |

#### Certification

I hereby agree to submit to a saliva analysis for the purpose of testing for drug metabolites. The specimen provided is my own and has not been substituted or altered.

NOAH HARRELL 08/31/17  
Donor Signature Date

*I hereby certify the specimen has been provided by the donor above.*

LAUREN KENNEY 8/31/17  
Collector Signature Date