0431500047

Custody Control Form

78177847

Lab ID: ALERE
Lab Panel ID: 1200
Lab Acct #: C10271220
Panels: 5 PANEL STANDARD (1200)

Alere Toxicology

Lab Address:
450 Southlake Blvd
Richmond, VA 23200

eScreen
PO Box 25902
Overland Park, KS 66225-5902
(800) 881-0722

Lab Acct #: C10271220

eScreen Company Account: 102712-20

STEP 1. **CMG**
12000 N Washington
Thornton CO 80241
866-920-1425
Lincoln Mooney

Medical Review Officer
Dr. Stephen Kracht
Dr. Stephen Kracht
7500 W. 110th St, Ste 400A
Overland Park KS 66225

Step 2. TO BE COMPLETED BY COLLECTOR
Specimen temperature for urine specimens must be read within 4 minutes of collection.
Specimen temperature within range: Yes

Verified Donor ID ☑

Step 3. TO BE COMPLETED BY COLLECTOR AND DONOR

Collector affixes bottle seal on specimen.

Type:

☑ Urine ☐ Oral ☐ Blood ☐ Hair ☐ Breath ☐ Split Specimen

STEP 4. Reason For Test:

☑ Pre-employment ☐ Return To Duty ☐ Promotion ☐ Periodic Medical ☐ Random ☐ Diversion

☐ Post Accident ☐ Follow Up ☐ Transfer ☐ Reasonable suspicion/cause ☐ Other _____

Step 5. TO BE VERIFIED BY DONOR

260-17-1171	6/29/1974	706-255-8181		
Donor SSN	**Date of Birth**	**Daytime Phone Number**	**Evening Phone Number**	**Other ID**

I certify that I provided my specimen to the collector, that I have not adulterated it in any manner, that the specimen bottle used was sealed with a tamper-evident seal in my presence, and that the information provided on this form and on the label affixed to the specimen bottle is correct. I hereby authorize the collector and testing service or laboratory (specifically including, but not limited to, eScreen, Inc.) to release the results of the test to the Company/Employer or their Designee.

Allyson Odum

Allyson Odum	1/12/2015 12:51 PM CST	
Donor's Name	**Date & Time**	**Signature of Donor**

Step 6. TO BE VERIFIED BY COLLECTOR

Name of Collection Site, Address, City, ST, Zip
Reddy Medical Group - Athens
1061 DOWDY RDSTE 100
ATHENS GA 30606

Collection Site ID
25621

I certify that the specimen identified on this form is the specimen presented to me by the donor providing the certification on Step 5 of this custody control form, that it bears the same specimen identification number as that set forth above, and that it has been collected, labeled and sealed as in accordance with applicable requirements.

Ann Njoroge	1/12/2015 12:51 PM CST	
Collector's Name	**Date & Time**	**Signature of Collector**

Remarks: *PHERNERGAN, PILL FOR INFLAMMATION, POPPY SEED SALAD DRESSING*

Step 7. LAB RECEIVED **Seal Intact:** ☐ Yes ☐ No **Shipper:** _____

Specimen Bottle(s) Released To	**Date & Time**	**Signature**

ORIGINAL MUST ACCOMPANY SPECIMEN TO LABORATORY

CMG
CORPORATE MANAGEMENT GROUP
"your workforce management & staffing experts"

ANTI-HARASSMENT POLICY

It is Corporate Management Group's (CMG) policy that all employees should be able to enjoy a work environment free from all forms of discrimination, including harassment. As such, CMG is committed to vigorously enforcing their Anti-harassment Policy. This policy applies to all employees of the organization (without regard to position) and individuals not directly connected to CMG (e.g., an outside vendor, consultant, customer or guest). Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, creed, religion, national origin, sex, marital status, status with regard to public assistance, membership or activity in a local commission, disability, sexual orientation or veteran status. Harassment is considered a form of discrimination and is specifically included among the prohibitions under Title VII of the Civil Rights Act of 1964. In addition, retaliation or reprisal taken against anyone who has expressed concern about harassment or discrimination against the individual raising the concern is illegal.

The Equal Employment Opportunity Commission (EEOC) defines sexual harassment as "unwelcome sexual advances, requests for sexual favors, sexual comments, or other verbal or physical acts of a sexual or sex-based nature including, but not limited to drawings, pictures, jokes, and/or teasing where (1) submission to such conduct is made either explicitly or implicitly a term or a condition of an individual's employment; (2) an employment decision is based on an individual's acceptance or rejection of such conduct; or (3) such conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment."

The Anti-harassment Policy prohibits harassment and/or retaliation by any individual employed by, doing business with or for, or visiting CMG. Employees who believe they have been the subject of harassment and/or retaliation or an employee who may have been witness to harassment and/or retaliation must report the incident immediately. Information and/or allegations must be reported to a manager of CMG **(by telephoning 866.920.1425 or 303.920.1425)**. Only those who have an immediate need to know, including the alleged target of harassment or retaliation, the alleged harassers or retaliators, and any witnesses may find out the identity of the complainant. All individuals contacted in the course of an investigation will be advised that all persons involved in a charge are entitled to respect and that any retaliation or reprisal against an individual who is an alleged target of harassment or retaliation, who has made a complaint, or who has provided information in connection with a complaint, is a separate violation of CMG's policy. All information will be disclosed only on a need-to-know basis to allow CMG to

investigate and resolve the incident. CMG recognizes the serious nature of harassment and therefore will endeavor to protect the employee who may have been subjected to harassment, any witnesses and the party against whom allegations have been filed to every possible extent.

Harassment is unlawful and has a negative impact on employees. Violation of the Anti-harassment Policy will not be tolerated by CMG and may result in discipline up to and including termination. Offensive acts or conduct have no legitimate business purpose; accordingly, any employee, regardless of his/her position within CMG, who it is determined has engaged in such conduct will be made to bear the full responsibility for such unlawful conduct.

With respect to sexual harassment, the following is prohibited:

1. Unwelcome sexual advances, request for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, especially where:

   - ☐ Submission to such conduct is made either explicitly or implicitly a term or condition of employment;
   - ☐ Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or
   - ☐ Such conduct has the purpose or effect of creating an intimidating, hostile or offensive working environment.

2. Offensive comments, jokes, innuendoes and other sexually-oriented statements.

If Harassment Occurs:

1. When possible, confront the harasser and tell him/her to stop. Sometimes a simple confrontation will end the situation.
2. If confrontation is unsuccessful, immediately contact your CMG supervisor to report the harassment.
3. An investigation will be conducted and appropriate action taken, including disciplinary measures. We will investigate, in confidence; all reported incidents of harassment and retaliation.

Employee Signature: Allyson R [illegible]

Date: 1/11/15

To: All Employees
Quien: *Todos Empleados*

From: Corporate Management Group & Employer Solutions Group
De: *Corporate Management Group y Employer Solutions Group*

Re: Stop Payment Check Fee
Re: *Tarifa de cheque parado*

Effective immediately, to replace a lost or stolen check, $50.00 will be deducted from the replacement check for a stop payment fee and for a reprocessing fee. *Efectivo inmediatamente, para reemplazar un cheque de sueldo perdido o robado, $50.00 de tarifa sera deducido de el cheque reemplazado para parar el cheque original y para procesarlo denuevo.*

If you lose your check, we will first have to verify that it has not been processed through the bank. If it has not, a new check will be issued, minus the $50.00 fee. *Si usted pierde su cheque, tendremos que verificar que no ha sido procesado en el banco. Si no, un cheque nuevo sera processado, menos las tarifa de $50.00.*

If your check is stolen, we will first need a copy of the police report before a new check can be reissued. After we receive a copy of the police report, a new check will be issued following the same procedures as listed above. *Si su cheque es robado, necesitaremos una copia de el reporte de policia antes de que un cheque nuevo sera procesado. Despues de obtener una copia del reporte de policia, un cheque nuevo sera procesado usando los mismos procedimientos mencionados arriba.*

If you have any questions regarding this new policy, please contact your On-Site Representative or the Corporate Office (303-920-1425). *Si usted tiene preguntas sobre esta poliza, por favor contacte a su representante de CMG o la oficina corporal al (303-920-1425)*

Thank you for your continued dedication and hard work!

Gracias por su dedicacion continua!

By signing below you are confirming that you understand the above policy.
Con su firma abajo usted esta confirmando que entiende la poliza descrita.

Signature/*Firma*: Allyson R Chinn
Date/*Fecha*: 1/11/15

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

Name: Allyson Odom

Address: 250 Epps Bridge PKwy Apt. 414 A.

Home Phone: 706 - 255-8181

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

1. **Name:** Martha Odom

   Phone (work):

   Phone (home): 770' 267-2749

2. **Name:** Tommy Odom

   Phone (work):

   Phone (home): 770-267-2749

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

Employee Acknowledgement Form (Temps)

I hereby acknowledge receipt of Storeroom Solutions Inc. "***Employee Safety Handbook***" which outlines important safety requirements and information for working as safety as possible. I agree to follow the safety and health rules as outlined in this handbook. I further understand that complete safety and health program requirements are published in the "*Safety Manual*" that can be obtained through my Site Manager or Project Leader.

Allyson R Ca 11/18/15

Employee Signature Date

Employer's Representative Date

Important: This receipt must be read, understood and signed by all Storeroom Solutions Inc. permanent and temporary employees. Temporary employees sign this hard-copy form. Permanent employees must document their training in the SSI Learning Center by taking the associated quiz.

Documentation Instructions:

Permanent Employees: The SSI Site Manager, or senior SSI employee, will ensure all personnel have read and understand the contents of this document. Please contact the Senior Director of Safety and Quality safety@storeroomsolutions.com if you have any questions. The employee must take the Employee Safety Handbook Quiz contained in the SSI Learning Center.

Temporary/Project Employees: The project leader or hiring manager will ensure all personnel have read and understand the contents of this document. Please contact the Senior Director of Safety and Quality safety@storeroomsolutions.com if you have any questions. The employee and leader or manager will sign this form file it on site. This form is a special interest item during implementation audits.

Employees: ***Please retain the handbook for future reference***.

Essential StaffCARE

Health Insurance Enrollment Form

Complete the Enrollment Form to Elect or Decline Coverage

- You **MUST** Complete the Enrollment Form for the New Hire Process
- You **MUST** Elect or Decline Medical Coverage on the Enrollment Form
- You **MUST** Sign the Bottom of the Form, even if you Decline Coverage
- Return the Enrollment Form to your Branch Manager
- Keep the Plan Information Packet for Your Records

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

The Essential StaffCARE Medical/Rx and Dental Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.204 and 26.212. The Term Life, Accidental Death and Dismemberment, and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

VSI-IND 219301-EMP | OFFICE USE ONLY | ReHire Date ___/___/_____

ENROLLMENT FORM - PLAN 2

EMPLOYEE INFORMATION (Must Be Filled Out)

USE BLACK or BLUE INK ONLY
ESC CU(NAV*SAD) P2 v13.0

Social Security Number 260-17-1171

Date of Birth 06/29/1974 Sex M F

Name Allyson Odum

Street Address 250 Epps Bridge Pkwy Apt 414A

City Athens State Ga Zip 30606

Home Phone 706-255-8181

Do you or any dependents have Medicare?

☐ Yes ☐ No If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date ___/___/_____

Names of Covered Person(s)

1.

2.

3.

BENEFIT SELECTION

Weekly Rates

MEDICAL

☐ $20.91 Employee Only

☐ $42.44 Employee + One

☐ $56.67 Employee + Family

☐ **NO to MEDICAL, TERM LIFE, and STD benefits.**

DENTAL

☐ $ 5.99 Employee Only

☐ $11.98 Employee + One

☐ $19.77 Employee + Family

☐ **NO**

TERM LIFE

☐ **YES** $0.60 Employee Only
$0.90 Employee + One
$1.80 Employee + Family

☐ **NO**

SHORT-TERM DISABILITY

☐ **YES** $4.20 Employee Only

☐ **NO**

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

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

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number ___-___-_____

Date of Birth ___/___/_____ Sex M F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name _____

Social Security Number ___-___-_____

Date of Birth ___/___/_____ Sex M F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name _____

Social Security Number ___-___-_____

Date of Birth ___/___/_____ Sex M F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY

RELATIONSHIP

Accidental Death & Dismemberment is part of the Term Life Benefit.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

▶ **Signature** Allyson R Odum Date 01/11/2015

Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen. If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck.
The time that the money goes into your account on pay day varies by bank.
Please allow until at least 10 am on your paydate for the deposit to show.

Please print

Check one of the following	Effective Date
☒ Start	☒ As Soon As Possible
☐ Stop	☐ Future Paydate ____/____/____
☐ Change	

Social Security Number: 260-17-1171

Name (Last, First Middle Initial): Odum Allyson R

Home Address Street	City	State	Zipcode
250 Epps Bridge Pkway Apt 414A	Athens	Ga.	30606

Date (Mo/Day/Yr)	Employee Signature	Daytime Phone Number
01/11/2015	Allyson R Odum	706-255-8181

SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION

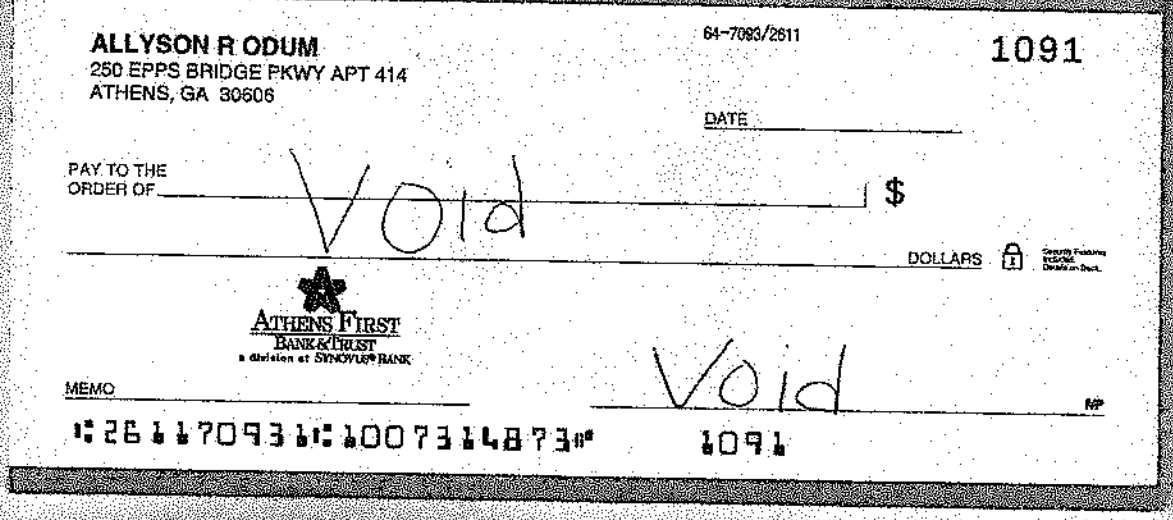
Financial Institution Name (Bank, Savings Institution, Credit Union, etc.): Athens First Bank and Trust

Type of Account

☒ Checking ☐ Savings ☐ Money Market Checking ☐ Money Market Investment Requires Submission of ACH form from your broker

I authorize Employer Solutions Staffing Group to direct deposit funds to my account in the financial institution listed above. If funds to which I am **not** entitled are deposited in my account, I authorize Employer Solutions Staffing Group to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by Employer Solutions Staffing Group at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to you will be returned to Employer Solutions Staffing Group for distribution. This will delay payment of funds to you.

✓ **Attach a voided check HERE or photocopy of a check for checking account.**
DO NOT ATTACH A DEPOSIT SLIP.



ALLYSON R ODUM
250 EPPS BRIDGE PKWY APT 414
ATHENS, GA 30606

64-7093/2611

1091

DATE

PAY TO THE ORDER OF Void $

DOLLARS

ATHENS FIRST BANK & TRUST
a division of SYNOVUS BANK

MEMO Void

⑆261170936⑆ 1007314873⑈ 1091

Employer Solutions Staffing Group LLC

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

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Odum **First Name** Allyson **Middle Initial** R

Street Address 250 Epps Bridge Pkwy Apt. 414A

City/State/Zip Athens, GA 30606

Home Phone _____ **Cell / Message Phone** 706-255-8181

Company/Employer Merial

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.

Allyson Odum — Name (Print or type)

Allyson R Odum — Applicant's Signature

1/11/15 — Date

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

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

HIRE Act FICA Payroll Holiday and Employee Retention Tax Credit

Employee Affidavit

Employer Name: _____ FEIN: _____

Hire Location: _____

Employee Name: Allyson Odum

Social Security Number: 260-17-1191 **1st Day of Work:** 1/13/15

EMPLOYEE: Please check one statement that applies to you and sign and date where indicated below.

☐ I was unemployed during the entire 60 day-period prior to my first day of employment at this company.

☐ I worked less than a total of 40 hours during the 60-day period prior to my first day of employment at this company.

OR

☒ I worked MORE than a total of 40 hours during the 60-day period prior to my first day of employment at this company.

Under penalties of perjury, I hereby declare that the information above is true and correct to the best of my knowledge. By signing this form, I hereby authorize the release to my new employer or its agents information held by any parties needed to determine my eligibility for federal and/or state incentive programs.

Employee Signature: Allyson R Odum Today's Date: 1/11/15

For employer's use only:

☐ Employee is being hired for a new position within the company.
☐ Employee is replacing an employee who either quit or was terminated with just cause.
☐ Employee is replacing an employee who was laid off.

Hiring Manager's Signature: _____ Date: _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the 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)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*
Odum	Allyson	R	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code
250 Epps Bridge Pkwy	414A	Athens	Ga.	30606

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
06/29/1974	260-17-1171	auntallyson@yahoo.com	706-255-8181

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):

☒ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write In This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:
Allyson R Odum	01/11/15

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:			Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

CERTIFICATE OF VITAL RECORD

VERIFY PRESENCE OF WATERMARK — HOLD TO LIGHT TO VIEW

Local File Number: 1123

STATE OF GEORGIA
CERTIFICATE OF LIVE BIRTH

State File Number: 110-74-042659

CHILD

1a. Child's Name: First ALLYSON; Middle REIEE; Last ODUM
1b. Date of Birth: No. 6; Day 29; Yr. 74
1c. Time of Birth: 5:16 A.M. P.M. (2)
1d. Sex: Male (1) Female (2) X
1e. This Birth: Single (1) X; Twin (2); Triplet (3); Other (4) —
1f. If not Single Birth (specify): Born 1st (1); Born 2nd (2) X; Born 3rd (3); Other (4)
1g. County of Birth: Clarke 059
1h. City, Town, or Location of Birth: Athens, Georgia 30601 250
1i. Hospital Name (If not in hospital, give street address or location): Athens General Hospital 005

MOTHER

2a. Mother's Name: First Martha; Middle Ann; Last Odum
Maiden Last Name: Thomas
2b. Mother's Birthplace: North Carolina
2c. Usual Residence—Street & Number, P.O. Box, Route, Etc.: 339 Woodland Rd.
2d. Mother's Birthdate: No. 10; Day 18; Yr. 50
2e. Race: White (1) X; Black (2); Other (3) —
2f. City: Monroe 380
2g. State and Zip Code: Georgia
2h. County: Walton 147
2i. Inside City Limits: Yes (1) X; No (2) —

FATHER

3a. Father's Name: First Thomas; Middle William; Last Odum, Jr.
3b. Father's Birthplace: Walton Co., Georgia
3c. Race: White (1) X; Black (2); Other (3) —
3d. Father's Birthdate: No. 3; Day 23; Yr. 45
4a. Signature of Either Parent: Martha Thomas Odum
4b. Relationship to Child: Father; Mother (2) X

PHYSICIAN OR OTHER ATTENDANT

5a. I certify that the above named child was born alive at the place and time and on the date stated above.
Signature: David Thompson M.D.
5b. Date Signed: No. 7; Day 9; Yr. 74
5c. Attended: Yes (1) X; No (2); Not Viable (3); Not Stated (4) —
5d. Physician or Other Attendant (Type or print the above Signature): D. L. Dranyon, M. D.
5e. Mailing Address (Street or R.F.D. No., City or Town, State): 1010 Prince Ave., Athens, Ga. 30601

LOCAL REGISTRAR

6a. Signature of Local Registrar: AUG 8 1974 George O. Thompson, M.D. (R)
6b. Date Filed: No. 7; Day 30; Yr. 74

VOID IF ALTERED OR ERASED

THIS IS TO CERTIFY THAT THIS IS A TRUE REPRODUCTION OF THE ORIGINAL RECORD ON FILE WITH THE STATE OFFICE OF VITAL RECORDS, GEORGIA DEPARTMENT OF PUBLIC HEALTH. THIS CERTIFIED COPY IS ISSUED UNDER THE AUTHORITY OF CHAPTER 31-10, CODE OF GEORGIA AND 290-1-6, DRH RULES AND REGULATIONS.

Any reproduction of this document is prohibited by statute. Do not accept unless on security paper with seal of Vital Records clearly embossed. Chapter 31-10, Code of Georgia as amended.

Form 1972 (Rev. 7-11)

Signed: [illegible]
State Registrar

Signed: [illegible]
County Registrar

COUNTY OF CLARKE — CERTIFIED COPY — VITAL RECORDS

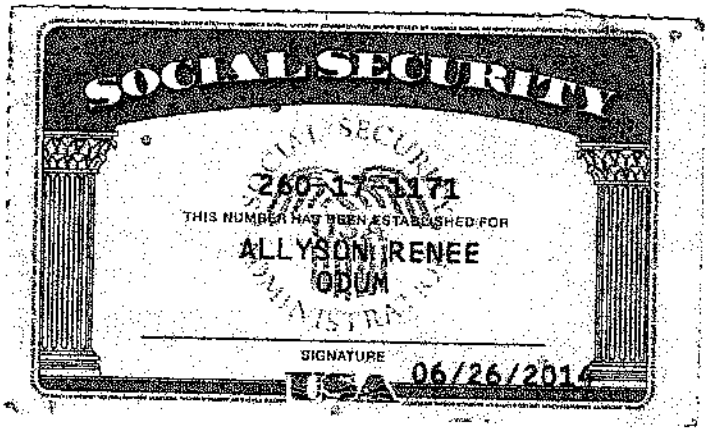
STATE OFFICE VITAL RECORDS

STATE OF GEORGIA 1776

WARNING: THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK. THE DOCUMENT FACE CONTAINS A SECURITY BACKGROUND, EMBOSSED SEAL AND THERMOCHROMIC INK. THE BACK CONTAINS SPECIAL LINES WITH TEXT.

S 738834

VOID IF ALTERED OR COPIED


SOCIAL SECURITY
260-17-1171
THIS NUMBER HAS BEEN ESTABLISHED FOR
ALLYSON RENEE
ODUM
SIGNATURE
USA
06/26/2014

employer solutions staffing group
Leveraging Resources in a Changing Market

Important/Importante

LOST OR STOLEN PAYCHECKS

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

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

CHEQUES DE PAGO PERDIDOS O ROBADOS

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

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

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Allyson Odum

Signature/Firma: Allyson R Odum

Form W-4 (2014)

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 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 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 do not apply to supplemental wages greater than $1,000,000.

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

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

Head of household. Generally, you 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 2014. 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
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 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

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

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

OMB No. 1545-0074

2014

1 Your first name and middle initial	Last name	2 Your social security number
Allison R	Odum	260-17-1171

Home address (number and street or rural route): 250 Epps Bridge Pkwy Apt. 414A

City or town, state, and ZIP code: Athens, Ga. 30606

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.

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 0
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

Employee's signature (This form is not valid unless you sign it.) ▶ Allison R Odum **Date** ▶ 1/11/2015

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)

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

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

▶ See separate instructions.

OMB No. 1545-1500

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

Your name Allyson Odum Social security number ▶ 260-17-1171

Street address where you live 250 Epps Bridge Pkwy Apt 414A

City or town, state, and ZIP code Athens, Ga 30606

County Clarke Telephone number (706) 255-8181

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

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

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

3 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  - **a** Received SNAP benefits (food stamps) for the past 6 months, **or**
  - **b** Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and,** for at least 4 weeks during the past year, I received unemployment compensation.
- I am at least age 16 but **not** age 25 or older, **and:**
  - **a** During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
  - **b** During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
  - **c** I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate **or** I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.

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

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

5 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months, **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ Allyson R Odum **Date** 01/11/2015

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

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

Name Allyson Odom
Address 250 Epps Bridge Pkwy
City Athens State Ga Zip 30606 Social Security # 260-17-1171
Date of Birth 06/29/1974 Age 40

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

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

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

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

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

5. **Name of person who received benefits** Allyson Odom
Relationship myself **City & State where benefits received** Athens, Ga 30606

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

7. Have you been unemployed at any time during the last 12 months? **Yes** ☒ **No** ☐
If yes, dates of unemployment: From: June 1, 2014 To: July 1, 2014
Did you receive unemployment compensation at any point during your unemployment?
If yes, dates received compensation: From: _____ To: _____ **Yes** ☐ **No** ☒

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

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

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

11. Did you receive a high school diploma or GED? If yes, date received: 06/92 **Yes** ☒ **No** ☐
Have you been employed or been admitted to technical school or college since then? **Yes** ☒ **No** ☐

12. How much in gross wages have you earned TOTAL in the past six months? $ 5,790

I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative, or the Department of Labor.

→ NEW HIRE SIGNATURE Allyson R Odom DATE 11/11/15

Questions below to be completed by manager
Starting Wage _____ Position _____
Has employee worked for this company before? _____ If yes, date and location _____

U.S. Department Labor
Employment and Training Administration

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

YOUTH SELF-ATTESTATION FORM
Work Opportunity Tax Credit Program

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

New Hire Name: Allyson Odum

Social Security Number: 260-17-1171 Date of Birth: 06/29/1974

Employer Name: Employer Solutions Staffing Group

Employer Federal ID (EIN) Number: -

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

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

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

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

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

New Hire's Signature: Allyson R Odum Date 1/11/15

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

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

Background Investigation Information Release Form

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

I understand that a successful criminal and driving record background investigation is a condition of my employment by Employer Solutions Staffing Group LLC to work at facilities of: Allyson Odum

and, further, that Employer Solutions Staffing Group may, at its discretion, conduct periodic criminal and driving record background investigations on me during the course of my employment with Employer Solutions Staffing Group.

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

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

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

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

260-17-1171	054685251	Ga.
Social Security Number	Driver's License No:	State
Odum	Allyson	R
Last Name	First Name	M.I

Odum
Maiden and/or Other Last Names Used

250 Epps Bridge Pkwy Apt 414A	Clarke, Athens	Ga. 30606
Current Address	City and County	State and Zip Code

06/29/1974
Date of Birth

Circle One:
Male (Female)

Signature: Allyson R Odum Date: 1/11/15


USA
Georgia
DRIVER'S LICENSE
DL NO. 054685251
CLASS C
DOB 06/29/1974
EXP 06/29/2019
ALLYSON R
ODUM
250 EPPS BRIDGE PKWY APT 414
ATHENS, GA 30606-8321
CLARKE
Restrictions A
End NONE
Iss 07/29/2014
Sex F
Hgt 5'-06"
Eyes BRO
Wgt 160 lb
DD 205922770350053807
DONOR