

Name: Daniel M. Podrasky /DOH: _____ PT/FT: PT

Phone Number: (347)330-7205 /CLIENT: _____ DAY/NIGHT

NEW HIRE APPLICATION

1. I-9
2. Affirmation of Legal Work Status
3. W-4
4. Application
5. 8850 Pre Screen
6. Youth Self-Attestation Form
7. Work Opportunity Tax Credit
8. Background Release Form
9. Injury Management Program release form
10. Emergency Contact
11. Unemployment Acknowledgement
12. Direct Deposit Form
13. Stop Payment Check Fee Release
14. Health Insurance

OFFICE USE ONLY:

1. E-Verify
2. Scan info. send / Kristin
3. Scan Ins. Form / Valerie
4. Scan attach/CMG Time
5. Drug Screen Auth.
6. Background Auth.
7. Mail originals/ESG



Employer Solutions Staffing Group LLC *New Hire Application*

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

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Podrasky First Name Daniel Middle Initial M
 Street Address 538 Dewey Avenue
 City/State/Zip Boulder CO USA 80301
 Home Phone _____ Cell / Message Phone (347) 330-7205
 Company/Employer _____

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.

Daniel M. Podrasky
Name (Print or type)

[Signature]
Applicant's Signature

3/30/12
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 _____ |

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

Form I-9, Employment Eligibility Verification

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

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

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

| | | | |
|---|------------------------|-----------------------------|---|
| Print Name: Last Podrasky | First Daniel | Middle Initial M. | Maiden Name _____ |
| Address (Street Name and Number) 12318 Clear Lake North Road East | | Apt. # _____ | Date of Birth (month/day/year) 10/16/1986 |
| City Eatonville | State WA | Zip Code 98328 | Social Security # 536-17-5866 |

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 #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year) _____

Employee's Signature

Date (month/day/year)

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

Preparer's/Translator's Signature

Print Name

Address (Street Name and Number, City, State, Zip Code)

Date (month/day/year)

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

| List A | OR | List B | AND | List C |
|---------------------------------|----|----------------------|-----|--------------------|
| Document title: _____ | | ID Card | | SS Card |
| Issuing authority: _____ | | State of Colo | | DHHS |
| Document #: _____ | | 11 151 0446 | | 536 17 5866 |
| Expiration Date (if any): _____ | | 10/16/16 | | NA |
| Document #: _____ | | | | |
| Expiration Date (if any): _____ | | | | |

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) **3/30/12** and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative

Print Name

Title

Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)

Date (month/day/year)

Employers Solutions Staffing Group

7301 OHMS LANE, SUITE 405

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

EDINA, MN 55439

A. New Name (if applicable)

B. Date of Rehire (month/day/year) (if applicable)

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

Document Title: _____

Document #: _____

Expiration Date (if any): _____

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

Signature of Employer or Authorized Representative

Date (month/day/year)

Colorado
Identification Card

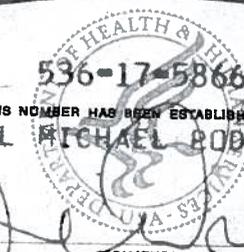


11-151-0446 Expires: 10-16-2016
Ht: 5'07" Issued: 10-07-2011
Wt: 160 DOB: 10-16-1986
Eyes: GRN Previous Type: A
Sex: M
Voter:

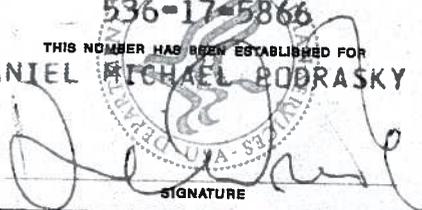
DANIEL MICHAEL PODRASKY
4545 WHEATON DR UNIT D130
FT COLLINS, CO 80525



SOCIAL SECURITY



536-17-5866
THIS NUMBER HAS BEEN ESTABLISHED FOR
DANIEL MICHAEL PODRASKY



SIGNATURE

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security
E-Verify

Report Prepared: 03/30/2012
Page: 1 of 1

Case Verification Number: 2012090182018AE

Case Information:**Employee Information:**

| | | | |
|-------------------------|--------------------------------|----------------|------------|
| Last Name: | DANIEL | First Name: | PODRASKY |
| Middle Initial: | M | Maiden Name: | |
| Social Security Number: | *** ** 5866 | Date of Birth: | 10/16/1986 |
| Citizenship Status: | A citizen of the United States | | |

Document Information:

| | | | |
|-------------------------------------|---|---------------------------|----------------------|
| List B Document: | Driver's license or ID card issued by a U.S. state or outlying possession | List C Document: | Social Security Card |
| Document Name: | ID card | Document State: | Colorado |
| Driver's License or ID Card Number: | | Document Expiration Date: | 10/16/2016 |
| Alien Number: | | I-94 Number: | |

Additional Information:

| | | | |
|------------------------|------------|-------------------------|------------|
| Hire Date: | 03/30/2012 | Employer Case ID: | |
| Three-Day Rule Reason: | | Three-Day Rule - Other: | |
| Submitted By: | MFON4558 | Submitted On: | 03/30/2012 |

Initial Case Result:

Case Result: Employment Authorized

Employee Referred to SSA:

Referred By: Referred On:

Case Result from SSA (after SSA Tentative Nonconfirmation):

Case Result: Response Date:

Resubmitted to SSA (after Review and Update Employee Data):

| | | | |
|-------------------------|--|-----------------|--|
| Last Name: | | First Name: | |
| Middle Initial: | | Maiden Name: | |
| Social Security Number: | | Date of Birth: | |
| Resubmitted By: | | Resubmitted On: | |

Case Result from SSA (after Resubmission):

Case Result:

Request Name Review:

Comments:
Submitted By: Submitted On:

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

Case Result: Response Date:

Employee Referred to DHS:

Referred By: Referred On:

Case Result from DHS (after DHS Tentative Nonconfirmation):

Case Result: Response Date:

Photo Matching Results:

Determination:

Employee Referred to DHS (Additional):



Affirmation of Legal Work Status
Pursuant to § 8-2-122, Colorado Revised Statutes

Employee Name: Podrasky Daniel Michael 10/16/86
Last First Middle Date of Birth

Social Security Number: 536 - 17 - 5866 Date of Hire: 3/30/12

In accordance with § 8-2-122, C.R.S., within twenty days after hiring the new employee listed above,

I affirm all four of the following:

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.

MARITH FORNEY
Daniel M. Podrasky
Print Name of Employer (or Designated Representative)

Recruiting Manager
Official Title

[Signature]
Signature of Employer (or Designated Representative)

3/30/12
Date Signed

Employer Solutions Staffing Group, LLC

7301 Ohms Lane, Suite 405

Edina, MN 55439

Business or Organization Name

303 920 1425
Employer Phone Number

§ 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.

This affirmation 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.

Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

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

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

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

| | | | |
|----------|--|----------|----------|
| A | Enter "1" for yourself if no one else can claim you as a dependent | A | <u>1</u> |
| B | Enter "1" if: <ul style="list-style-type: none"> • 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 | <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 | _____ |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return | D | _____ |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) | E | _____ |
| F | Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | F | _____ |
| G | Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children | G | _____ |
| H | Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ | H | <u>2</u> |
| | For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. | | |

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

| | | |
|---|--|---|
| Form W-4 Department of the Treasury Internal Revenue Service | <h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ 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.</p> | OMB No. 1545-0074 <h1 style="margin: 0;">2011</h1> |
| 1 Type or print your first name and middle initial. Last name <u>Daniel M. Podrasky</u> | | 2 Your social security number <u>536-17-5866</u> |
| Home address (number and street or rural route) <u>12318 Clear Lake North Road East</u> | | 3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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>Eatonville, WA 98328</u> | | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/> |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) | | 5 <u>2</u> |
| 6 Additional amount, if any, you want withheld from each paycheck | | 6 \$ <u> </u> |
| 7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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 <u> </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.) ▶ | | Date ▶ <u>3/30/12</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) |

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

OMB No. 1545-1500

▶ See separate instructions.

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

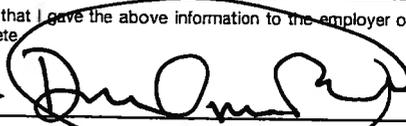
Your name Podrasky, Daniel M. Social security number ▶ 536-17-5866
Street address where you live 538 Dewey Avenue
City or town, state, and ZIP code Boulder CO
County USA 80301 Telephone number (347) 330-7205
If you are under age 40, enter your date of birth (month, day, year) 10/16/86

- 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 ▶



Date 3/30/12

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

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

Name Podrasky, Daniel Michael
Address 538 Derby Avenue
City Boulder State CO Zip 80301 Social Security # 536-17-5866
Date of Birth 10/16/86 Age 25 yo

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 Daniel M. Podrasky
Relationship Self (HOH) City & State where benefits received Boulder, CO USA

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: 2007 To: 2012

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: 2002 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? \$ 0.00

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 [Signature] DATE 3/30/12

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



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: Podrasky, Daniel Michael

Social Security Number: 536-17-5866 Date of Birth: 10/16/86

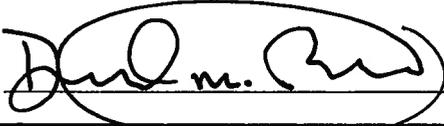
Employer Name: Employer Solutions Staffing Group

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:  Date 3/30/12

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 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 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:

Corporate Management Group

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.

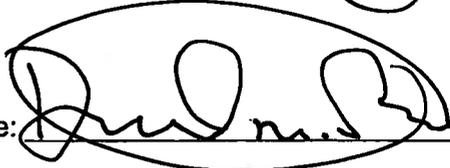
I do hereby fully release and discharge Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims from damages that I may have or that may accrue to me on account of the results of any aspect of any criminal and driving record background investigation.

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.

S36-17-5866 _____ N/A _____
Social Security Number Driver's License No: State
Podrasky _____ Daniel _____ m. _____
Last Name First Name M.I.

Maiden and/or Other Last Names Used N/A
S38 Dewey Avenue _____ Boulder _____ CO USA 80301
Current Address City and County State and Zip Code
10/16/86 _____
Date of Birth Circle One: Male Female

Signature: 

Date: 3/30/12

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 Colorado workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

- **I have been hurt on the job, what do I do?**

If you experience a life or limb threatening injury on the job, seek immediate medical attention at the nearest emergency room and then notify your supervisor in writing. A life or limb threatening injury means an injury that you believe threatens a portion of your body or your life in such a way that immediate medical care is needed to prevent your death or serious damage. In all other instances, notify your employer or supervisor that you have been injured before obtaining any medical care. All injuries, no matter how small, should be reported to your employer.

If your employer has designated a medical provider before or at the time of the injury, you will be required to see that provider for medical care. If you choose to seek your own medical care it may result in nonpayment of medical benefits and you may be liable for your medical costs. If your employer does not direct you to a medical provider, you may seek treatment from the provider of your choice.

By law, you must notify your employer in writing within four working days of an injury, even if you have advised them verbally. If you do not report your injury to your employer in writing within four working days, you may be penalized and lose up to one day's compensation for each day's delay, provided that your employer has posted a sign requiring four days' written notice. You may still file a claim for benefits even if you are late reporting the injury to your employer.

Your employer has the right in the first instance to designate the medical provider that injured employees must use. If your employer does not do so at the time of the injury, you may choose your own medical provider.

After the claim is filed, the insurance company may request that you be examined by another doctor of its choice, at its expense. If you do not go to this examination, the insurance company may ask the Division for permission to stop your benefits.

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. Colorado rules 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.

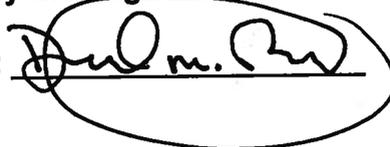
Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

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.

Printed Name: Daniel M. Podasky Signature: 

DATE: 3/30/12

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

Name: Podrasny, Daniel M.
Address: 538 Dewey Avenue Boulder CO USA 80301
Home Phone: (347) 330-7205

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

1. Name: Patti Podrasny
Phone (work): *(253) 906-3910 *
Phone (home): (310) 832-8238
2. Name: Betty May
Phone (work): *(425) 746-1308 *
Phone (home): _____

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

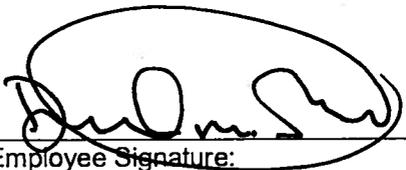


Notification of Colorado Law Requirement – Unemployment Acknowledgement

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 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. DM (Initial)


Employee Signature:

3/30/12
Date:

Daniel H. Podrasny
Employee (please print your name here)



employer solutions staffing group^{llc}

Leveraging Resources in a Changing Market

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 demuevo.*

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: _____

Date/Fecha: _____

3/30/12

EMPLOYEE INFORMATION
(Must Be Filled Out)

ENROLLMENT FORM - 10k PLAN

USE BLACK or BLUE INK ONLY

Social Security Number **536-17-5866**

Date of Birth **10/16/1986** Sex F

Name **Podrasky, Daniel M.**

Street Address **12318 Clear Lake North Road East**

City **Castroville** State **WA** Zip **98328**

Home Phone **347-330-7205**

Do you or any dependents have Medicare?

Yes No If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date //

Names of Covered Person(s)

- 1.
2.
3.
4.

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

BENEFIT SELECTION

Weekly Rates

MEDICAL

- \$20.91 Employee Only (checked)
\$42.44 Employee +1
\$56.67 Employee + Family
NO to MEDICAL, TERM LIFE, and STD benefits.

DENTAL

- \$5.99 Employee Only (checked)
\$11.98 Employee +1
\$19.77 Employee + Family
NO

TERM LIFE

- YES \$0.60 Employee Only
\$0.90 Employee +1
NO \$1.80 Employee + Family

SHORT-TERM DISABILITY

- YES \$4.20 Employee Only
NO

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

REQUIRED DEPENDENT INFORMATION

Name
Social Security Number
Date of Birth
Sex M F
Relationship: Spouse Domestic Partner Child

Name
Social Security Number
Date of Birth
Sex M F
Relationship: Spouse Domestic Partner Child

Name
Social Security Number
Date of Birth
Sex M F
Relationship: Spouse Domestic Partner Child

Name
Social Security Number
Date of Birth
Sex M F
Relationship: Spouse Domestic Partner Child

BENEFICIARY INFORMATION

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

NAME OF BENEFICIARY

RELATIONSHIP

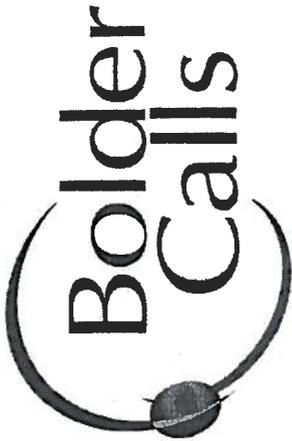
Accidental Death & Dismemberment is part of the Medical Benefit.

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

Signature [Handwritten Signature]

Date 03/30/2012

cmg



Innovative Telebusiness Solutions

TSR Permanent Schedule

| Day | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|-------|-----------------|---------|-----------|----------|--------|-----------------|--------|
| Hours | 2-10 | 2-10 | 2-10 | 2-10 | 2-10 | 2-10 | 9-530 |

Name (Printed): David
 TSR Signature: [Signature]
 Supervisor Signature: [Signature]

Date: 3/30/12
 Date: 3/30/12
 Date: 3/30/12

TSR Training Schedule

| Day | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|-------|--------|---------|-----------|----------|--------|----------------|----------------|
| Date | 4-7 | 4-8 | 4-4 | 4-5 | 4-6 | 4-7 | 4-8 |
| Hours | 2:30-9 | 3-9 | 3-9 | 3-9 | 3-9 | 3-9 | 3-9 |

(247) 330-7205