

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Graves First Name Sandra Middle Initial S
 Street Address 6804 117th St NW Apt. _____
 City/State/Zip Oronogo MN 55960
 Home Phone 507-271-89 Cell / Message Phone _____
 Company/Employer ESSG

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 rehiring.
 I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.
 I release ESSG and other persons or entities from any claims that might be based on ESSG's decision to conduct a background check. I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.
 If hired, I agree to abide by the policies and procedures of ESSG.

Name (Print or type) Sandra Graves
 Applicant's Signature Sandra Graves
 Date 02-26-2013

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

For ESSG Office Use Only

Emergency Contact Info	Background Release Form	Background Results	Unemployment Letter (if applicable)	ESSC Application
DOH	NHW	I-9	8850	W4

[illegible]

Phone (work):
Phone (home): 1612-991-6199

- | 1. | Name: | Phone (work): | Phone (home): |
|----|-----------------|---------------|--------------------|
| | Debbie aldrIDGE | | Cell: 507-226-2841 |
-
- | 2. | Name: | Phone (work): | Phone (home): |
|----|--------------|---------------|---------------|
| | David Graves | | |

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

Home Phone: 507 - 226-2841

Address: 6804 117th St NW, Crofton MN. 55960

Employee Name: ~~John Doe~~ Jane Doe

STATEMENT OF CONFIDENTIALITY

This agreement made this 20th day of July, 2013, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and _____ hereafter referred to as "employee".

WITNESSETH:

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

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

Employee Signature

Employer Solutions Staffing Group LLC, Representative

INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

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

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

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

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

I have read my responsibilities and agree to abide by these guidelines.

Signed: Danada Graves

Printed Name: Danada Graves

Form W-4 (2013)

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 2013 expires February 17, 2014. 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).

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 remitted 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 for information on

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 1382, 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 2013. 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.
- 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.
- 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.)
- D** Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.
- E** Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).
- 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.)
- 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.
- 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.)
- 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 \$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.

Employee's Withholding Allowance Certificate

Form W-4 Department of the Treasury Internal Revenue Service

OMB No. 1545-0074 **2013**

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

1 Your first name and middle initial **Sandra**

2 Your social security number **473-66-6116**

3 ☒ Single ☐ Married, but with child ☐ Married, but with child 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. **Graves**

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) **5**

6 Additional amount, if any, you want withheld from each paycheck **\$**

7 I claim exemption from withholding for 2013, 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.

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 *Sandra*

(This form is not valid unless you sign it.)

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) **02-26-8013**

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 Graves		First Sandra	Middle Initial S
Address (Street Name and Number) 6504 117th St NW		City Orlando	State MN
Date of Birth (month/day/year) 02-25-1955		Zip Code 55940	Social Security # 473-66-6110

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)

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.

Employee's Signature Sandra Graves	Date (month/day/year) 02-26-2013
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Preparer's/Translator's Signature

Print Name

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: Instruction Permit Document #: 12.24.14 Expiration date (if any): 022291210404 Issuing authority: State of Minnesota Document #: 473-66-6110 Expiration date (if any): 022291210404				Document title: Social Sec. Card Document #: 473-66-6110 Expiration date (if any): 022291210404

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) 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 Sandra Graves	Print Name Sandra Graves	Date (month/day/year) 02/26/2013
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Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)
EMPLOYER SOLUTIONS STAFFING GROUP 7301 OHMS LANE, STE 405 EDINA, MN 55439

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

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

Signature of Employer or Authorized Representative

Date (month/day/year)

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:

Beck's Foods

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.

Social Security Number 473-66-6110
 Last Name Graes
 First Name Sandra
 State MN M.I. S
 Maiden and/or Other Last Names Used Ziemann
 Current Address 6804 117th St NW
 City and County Orono MN State and Zip Code 55960
 Date of Birth 02-25-1955
 Circle One: ☒ Male / ☐ Female

Signature: Sandra Graes Date: _____

8850

Form 8850
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

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

► See separate instructions.

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

Your name

Danilo Henry

Social security number ►

Street address where you live

684 117th St NW

City or town, state, and ZIP code

Atlanta GA 30309

County

Alm.

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

1

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

2

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

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but not age 40 or older and I am a member of a family that:
 - a Received SNAP benefits (food stamps) for the past 6 months, or
 - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3

Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4

Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5

Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6

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

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

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 ►

Danilo Henry

Date

09 26 2013

WORK OPPORTUNITY TAX CREDIT

Form A (revised 07/09)

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

Name Sandra J. Graves Address 6504 117th St NW City Shoreline State MN Zip 55960 Social Security # 473-66-6110 Date of Birth 02-25-1955 Age 53

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

- 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 ☒
- 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 ☐
- Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days? Yes ☐ No ☒
- Are you part of the Ticket to Work program? Yes ☐ No ☒

5. Name of person who received benefits Sandra Graves City & State where benefits received Shoreline, MN

- Are you a veteran? Yes ☐ No ☒ and Disabled due to service? Yes ☐ No ☐ Service Dates: From: _____ To: _____ Branch: _____
- Have you been unemployed at any time during the last 12 months? Yes ☒ No ☐ If yes, dates of unemployment: From: _____ To: _____ Did you receive unemployment compensation at any point during your unemployment? Yes ☐ No ☒ If yes, dates received compensation: From: _____ To: _____
- Have you been convicted of a felony or released from prison in the last 12 months? Yes ☐ No ☒ Date of Conviction: _____ Date of Release: _____ Parole Officer's Name: _____ Parole Officer's Phone # _____
- 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 _____

- 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 ☒
- Did you receive a high school diploma or GED? If yes, date received: _____ Yes ☐ No ☒ Have you been employed or been admitted to technical school or college since then? Yes ☐ No ☐
- How much in gross wages have you earned TOTAL in the past six months? \$ 0

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 Sandra Graves

DATE 02-25-2013

Questions below to be completed by manager

Starting Wage _____ Position _____

Has employee worked for this company before? _____ If yes, date and location _____

NOTICE OF WAIVER FROM ANNUAL LIMIT REQUIREMENT

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by BCS Insurance Company does not meet the minimum standards required by the Affordable Care Act describe above. Instead, it puts an annual limit on the following plans offered:

Annual Limit	Plan
Both inpatient & outpatient benefits	\$10,000
Outpatient benefits only	\$1,500
Prescription drugs	Subject to outpatient maximum of \$1,500

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 in 2011. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing \$750,000 in coverage for key benefits in 2011 would result in a significant increase in premiums or a significant decrease in access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to www.HealthCare.gov

If you have any questions or concerns about this notice, contact the Essential StaffCARE Customer Service at 866-798-0803.

In addition, you can contact:

Minnesota Department of Commerce
Consumer Concerns

Toll-free- (800) 657-3602 / Main – (651) 296-2488

Notification of Minnesota Law Requirement – Unemployment Acknowledgement

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

It is your responsibility to contact ESSG (for instance, by calling (507) 398.4567 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

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

Employee Signature: [Signature]
 Date: 02-26-2013
 Employee (please print your name here) Sandra Sean Graves

Acknowledgement of Receipt Antiharassment Policy

I certify that I have received a copy of Employer Solutions Staffing Group's Antiharassment Policy. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at 952.835.1288/1.866.496.7573 with any questions I may have about this policy. I agree to comply with ESSG's policy on Antiharassment and understand failure to comply is grounds for disciplinary action, up to and including termination. I also agree that if at any time during my employment I am involved in any employment dispute or I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, marital, sexual orientation or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact my supervisor, manager, director or ESSG's Human Resource Department at 952.835.1288/1.866.496.7573 in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Sandra Graves

Employee's Signature:

Sandra Graves

Date:

02-06-2013

RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT

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

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

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

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

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

DATE 02-26-2013

EMPLOYEE NAME Sandra Graves
PLEASE PRINT
EMPLOYEE SIGNATURE Sandra Graves
ESSG REPRESENTATIVE Kelly Adkins



ACKNOWLEDGMENT

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

1. This handbook is intended as a guide and not an employment agreement that creates a contractual relationship, and that the employment relationship may be terminated at the will of either party at any time.

2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.

3. I agree to **notify** my ESSG Consultant **immediately** of any change in my personal data such as phone number, address, emergency notification, etc.

4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my ESSG Consultant.

Date:

02-26-2013

Associate's Signature:

Sandra Graves

Associate's Printed Name:

Sandra Graves

Orientation provided by:

Kyley Adkins

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6

Date

2-25-2013

Individual's Name

Danilo

- related to the test.
- disclosure to ESSG of the results of my drug and/or alcohol test and other information analysis on the sample provided by me. I further voluntarily consent to the laboratory's understand that the laboratory selected by ESSG may conduct testing and other urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I other persons or entities acting for or with them, to collect a body component (blood, 4. I hereby voluntarily consent to ESSG, or its health service providers, or
- policy, are not a unilateral employment contract or offer thereof.
- understand that this policy in any form, and any employee handbook including this in adverse personnel action, including my termination from employment with ESSG. I exercise certain rights; and (d) that certain events as described in the policy may result consequences of such conduct; (c) my rights under the policy and the consequences if I understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the 2. I have read the entire contents of this policy and I am aware and fully
1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

DRUG AND ALCOHOL
TESTING CONSENT FORM