

<b>For ESSG Office Use Only</b>				
DOH	NHW	1-9	8850	W4
Emergency Contact Info	Background Release Form	Background Results	Unemployment Letter (if applicable)	ESC Application
<b>For ESSG Client Use</b>				
DOH	ROP	Work Site Loc.	WC Code	

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

Name (Print or type) Sirena Mares  
 Applicant's Signature Sirena Mares  
 Date 1-19-2015

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.

**Applicant Certification and Authorization**

Are you legally authorized to work in the United States of America?  YES  NO

All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

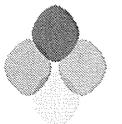
Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Mares First Name Sirena Middle Initial B  
 Street Address 1915 S. Garland Ct. Apt/Ste \_\_\_\_\_  
 City/State/Zip Lakewood CO.  
 Phone Number 720-254-7621 Email Address Smares@rams.colos.tate.edu  
 Company/Employer \_\_\_\_\_

**New Hire Application**

7301 Ohms Lane Suite 405  
 Edina, MN 55439  
 Tel: 952.835.1288 • Fax: 952.835.1255  
 www.esstaffingsolutions.com

empoyer solutions staffing group  
 Leveraging Resources in a Changing Market



# 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 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 may not be based on 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

## 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.

**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.

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  
2013

**1** Your first name and middle initial  
**2** Your social security number  
**3**  Single  Married, but withheld at higher Single rate.  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)  
**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.

**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)  
Date: 1-19-2015  
Employee's signature: Sylene Marks  
(This form is not valid unless you sign it.)

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.



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

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

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

Signature of Employee: <i>Belena Mares</i>	Date (m/dd/yyyy): <i>01/19/2015</i>
--------------------------------------------	-------------------------------------

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

Country of Issuance: \_\_\_\_\_

Foreign Passport Number: \_\_\_\_\_

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

2. Form I-94 Admission Number: \_\_\_\_\_

**OR**

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

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

3-D Barcode  
Do Not Write in This Space

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

A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_

A noncitizen national of the United States (See instructions)

A citizen of the United States

I attest, under penalty of perjury, that I am (check one of the following):

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.

Date of Birth (m/dd/yyyy) <i>07-16-1988</i>		U.S. Social Security Number <i>522-67-1795</i>		E-mail Address <i>Smars@fams.calstate.edu</i>		Telephone Number <i>720-254-7621</i>	
Address (Street Number and Name) <i>1915 S. Garland Ct</i>		Apt. Number _____		City or Town <i>Lakewood</i>		State <i>CO</i> Zip Code <i>80227</i>	
Last Name (Family Name) <i>Mares</i>		First Name (Given Name) <i>Sirena</i>		Middle Initial <i>R</i>		Other Names Used (if any) _____	

**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.)

▶ **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.



## Employment Eligibility Verification

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

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
-----------------------------------------------------	--------------------	------------------------------------------------------

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.

Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):
-----------------	------------------	---------------------------------------

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
--------------------------------------------------------------------------------------------	-------------------------------------------------

Employer's Business or Organization Address (Street Number and Name) City or Town	State	Zip Code	EDINA
7301 OHMS LANE SUITE 405		MN 55439	
Last Name (Family Name) First Name (Given Name)		EMPLOYER SOLUTIONS STAFFING GROUP LLC	
Signature of Employer or Authorized Representative	Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions.)

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

**Certification**

Document Title:	Expiration Date (if any)(mm/dd/yyyy):
Document Title:	Document Number:
Document Title:	Issuing Authority:
Document Title:	Expiration Date (if any)(mm/dd/yyyy):
Document Title:	Document Number:
Document Title:	Issuing Authority:
Document Title:	Expiration Date (if any)(mm/dd/yyyy):
Document Title:	Document Number:
Document Title:	Issuing Authority:
Document Title:	Expiration Date (if any)(mm/dd/yyyy):

3-D Barcode  
Do Not Write in This Space

Identify and Employment Authorization **OR** List B AND List C Employment Authorization

Employee Last Name, First Name and Middle Initial from Section 1:
-------------------------------------------------------------------

**Section 2. Employer or Authorized Representative Review and Verification**

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

**EMERGENCY CONTACT INFORMATION**

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

Employee Name: Sirena Mars

Address: 1915 S. Garland Ct

Home Phone: ~~303~~ 720-254-7621

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

<p>Home Phone: 303 985 2191</p> <p>Cell Phone:</p> <p>Work Phone:</p>	<p>Relationship: Grandpa</p> <p>Name: Virginia Mars</p> <p>Contact #1</p>
<p>Home Phone: 303 985 2191</p> <p>Cell Phone:</p> <p>Work Phone:</p>	<p>Relationship: Grandpa</p> <p>Name: Herman Mars</p> <p>Contact #2</p>

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

---



---



---



---



---

**Direct Deposit/Payroll Debit Card Authorization**

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card. If you do not provide a written election, wages will be paid by Payroll Debit Card.

**SECTION 1 BASIC INFORMATION**

Employee Name: Sirena Mares SSN# (last 4 digits) 1795 Effective Date 1-19-2015

**SECTION 2 PAYROLL ELECTION**

Direct Deposit (Please complete Sections 3 and 5 below)  
 Payroll Debit Card (Please complete Sections 4 and 5 below)

**SECTION 3 DIRECT DEPOSIT**

<input type="checkbox"/> Update Bank Account	Bank Name: <u>Key Bank</u>
	Routing# <u>307070267</u>
	Account# <u>766992018651</u>
	Account Type: <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Other

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

Initial SM Date \_\_\_\_\_

**SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)**

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.

Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

**CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)**

First Name	M.I.	Last Name	Date of Birth
Street Address (PO BOX NOT ACCEPTABLE)			
City	State	Zip	Cell Phone (mobile)

**GET TEXT ALERTS**, when your paycheck is deposited on your card! All we need to know your cell phone service provider and mobile number above!  Yes, sign me up, for text alerts  My mobile service provider is:

RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)

Payroll Debit Card Routing # 122242597  
 Payroll Debit Card Account # \_\_\_\_\_

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

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 5 AUTHORIZATION**

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

\* E-mail: ~~smares@~~ smares@rams.colostate.edu  
 this information will only be used to send your paystubs electronically  
 Employee's Signature: Sirena Mares Date: 1-19-15

**STATEMENT OF CONFIDENTIALITY**

This agreement made this 19 day of January, 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Sirena Mares 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.

Sirena Mares  
Employee Signature

Employer Solutions Staffing Group LLC, Representative

**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 Sirena Mares Social security number 825-522-67-1795  
 Street address where you live 1915 S. Garland Ct.  
 City or town, state, and ZIP code Lakeview CO. 80227  
 County USA Jefferson Telephone number 720-254-7621  
 If you are under age 40, enter your date of birth (month, day, year) 07-16-1988

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 Sirena Mares

Date 01-19-2015

TAX CREDIT QUESTIONNAIRE



EMPLOYER SECTION:

ESG FEIN#:	ESG Client Name & State:
Hiring Manager:	Position:
Starting Wage: \$	

EMPLOYEE SECTION:

Employee Name:	Street Address:	City/State:	Zip:
Sirena Wares	1915 S. Garland Ct	Lakewood Co.	80227
SS#: 522-67-1795	Date of Birth: 07/16/1988	Age: 26	Have you worked for this company before? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If yes, location:			

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

1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.)

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_  
 Name of the person receiving benefits: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 (If yes, please provide information below.)

2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_  
 Name of the person receiving benefits: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 (If yes, please provide information below.)

3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?

Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits.  
 (If yes, please provide information below.)

4. Have you received any type of vocational rehabilitation services within the past two years?

If yes, please indicate which type of agency you worked with and provide their location information below:  
 Vocational Rehabilitation Agency  Dept. of Veterans Affairs  Employment Network (Ticket to Work Program)  
 Name of Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_  
 (If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.)

5. Are you a Veteran of the U.S. Military? \*If yes, please provide information below. If no, please continue to question #6.)

Dates of Service - From: \_\_\_\_\_ To: \_\_\_\_\_  
 Branch of Service: \_\_\_\_\_  
 Are you entitled to or are you receiving compensation for a service-connected disability?  
 Yes  No  
 If yes, dates of unemployment - From: \_\_\_\_\_ To: \_\_\_\_\_  
 Did you receive unemployment compensation at any point during your unemployment?  
 Yes  No

6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?

Conviction Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Release Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Was this a  Federal or  State conviction? If State - County: \_\_\_\_\_ State: \_\_\_\_\_

Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe?  Yes  No  
 \*If you checked yes please provide a copy of your C/DIB card.

CA Residents:  Are you the child of foster parents?  Do you receive CalWorks?  Workforce Investment Act?  
 Are you a migrant or seasonal farm worker?  Have you ever been convicted of a misdemeanor?

SC Residents:  Do you receive Family Independence Benefits?

PLEASE READ, SIGN, AND DATE:

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

New Employee Signature: Sirena Wares

Date: 1-19-2015

# 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.

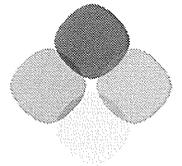
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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:** Silva Mares

**Printed Name:** Silva Mares



# Importante/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): *Silvia Mares*

Signature/Firma: *Silvia Mares*

**Notification of Colorado Law Requirement –  
Unemployment Acknowledgement**

According to Colorado Statutes section 8-73-105.3. A temporary employee who is given a notice that the employee is required to contact or notify the employer upon completion of an assignment and to be available to work, as agreed upon at the time of hire, during a specified period of time, on specified dates, or upon call by the employer on an as-needed basis and who does not contact or notify the employer upon completion of an assignment in compliance with the notice and is not available to work at the agreed-upon times is deemed to have voluntarily terminated employment for the purpose of determining benefits pursuant to section 8-73-108 (5) (e). Also, a temporary employee who agrees to work on an as-needed basis and refuses all work within three separate pay periods when contacted by the employer is deemed to have voluntarily terminated employment for reasons that may or may not allow an award of benefits pursuant to section 8-73-108.

It is your responsibility to contact or notify ESSG (For example, by calling 303-920-1425, or using another means of contact) once your assignment ends. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact or notify ESSG once an assignment ends. I also acknowledge that I have received a separate copy of this form. S M (Initial)

Employee Signature: Silvia Mares  
Date: 1-19-2015  
Employee (please print your name here) Silvia Mares

### CSS Inc.

I wish to receive a free copy of any Consumer Report and/or Investigative Consumer Report on me that is requested.

#### CALIFORNIA, MINNESOTA AND OKLAHOMA APPLICANTS ONLY:

Applicant Signature Sirena Mares Date 01-19-2015

City/State/Zip Lakewood CO. 80227

Present Address 1915 S. Garland Ct.

Drivers License Number and State of Issue 04-355-0419 Colorado

Social Security # 522-67-1795 Date of Birth (for ID purposes only) 07-16-1988

Applicant Last Name Mares First Sirena Middle B.

#### CONSENT

**Washington State:** If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

**New York:** You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may inspect and receive a copy of the report by contacting that agency.

**Maine:** You have the right, upon request, to be informed of whether an investigative consumer report was requested, and if one was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from the company, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any such reports.

**California** residents, under section 1786.22 of the California Civil Code, you may view the file maintained on you by CSS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at CSS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

**Additional State Law Notices:** If you live or are applying for a job in California, Maine, New York or Washington, please note:

This form, which you should read carefully, has been provided to you because CMG may request Consumer Reports and/or Investigative Consumer Reports from a consumer reporting agency. The Company will use any such report(s) solely for employment-related purposes. Consumer Reports or Investigative Consumer Reports will be obtained from CSS Test, Inc. ("CSS Test") located at 400 Laurel Oak Road, Suite 102, Voorhees NJ, 08043. They can be contacted at 856-627-5600. Under the provisions of the Fair Credit Reporting Act, 15 USC, Section 1681 et seq, the Americans with Disabilities Act, the Drivers Privacy Protection Act and all other applicable federal, state, and local laws, I hereby authorize and permit CSS Test, Inc., to obtain a consumer report and/or an investigative consumer report which may include the following: Reports may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include, but are not limited to: credit reports, social security number, criminal records checks, public court records checks, including civil, driving records, educational records, verification of employment positions held, workers compensation records, personal and professional references, licensing, certification, etc. The information contained in these reports may be obtained by CSS Test from private or public record sources including sources identified by you in your job application or through interviews or correspondence with your past or present coworkers, neighbors, friends, associates, current or former employers, educational institutions or other acquaintances.

### DISCLOSURE AND CONSENT CONCERNING CONSUMER AND INVESTIGATIVE CONSUMER REPORTS

**Colorado** ★  
**Driver License**

**04-355-0419** Expires: **07-16-2019**  
 Class: R Issued: **02-14-2014**  
 End: **07-16-1988**  
 Rest: C DOB: **07-16-1988**  
 Previous Type: A  
 HT: 5'01" Wt: 130 Eyes: BRO Sex: F



SIRENA BIANCA MARES  
 1805 S SHIELDS ST APT F-4  
 FT COLLINS, CO 80526

**SOCIAL SECURITY**

CIVIL SERVICE

THIS NUMBER HAS BEEN ESTABLISHED FOR

**522-67-1795**

SIRENA BIANCA MARES

*Sirena Mares*  
 SIGNATURE

MINISTERS

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security Report Prepared: 01/19/2015 Page: 1 of 1

Case Verification Number: 2015019142926MW

Case Information:

Employee Information:

Last Name: Mares First Name: Sirena Social Security Number: \*\*\* \*\* 1795 Date of Birth: 07/16/1988 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 Document Name: Driver's license Document State: Colorado List C Document: Social Security Card Document Expiration Date: 07/16/2019 Alien Number: 1-94 Number: 07/16/2019

Additional Information:

Hire Date: 01/19/2015 Three-Day Rule Reason: EPOR4912 Employer Case ID: Three-Day Rule - Other: 01/19/2015

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: Other Names Used: Date of Birth: Resubmitted On: Middle Initial: Social Security Number: 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: