

CORPORATE MANAGEMENT GROUP

Employment Application

Office Hours: 9am-4pm Mon-Thur, 9am-3pm Fri

Office Number: 507-923-4955

Office Address: 3707 Commercial Dr. SW Rochester, MN 55902



Applicant Information

(APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS AND A BACKGROUND CHECK WILL BE COMPLETED)

Please fully complete pages 1-3

Full Name: (Last Name, First Name) Oman Teekawok Date: 11-20-17

Address: (Street Address) 3094 25th St NW (Apt. /Unit #) 112

(City) Rochester (State) MN (ZIP Code) 55901

Phone: 507-517-7980 Email: _____

Social Security No. 504-25-6714 Date Available: Any day

Position Applied for: _____ Desired Salary: _____

Shift Available to work: __ 1st ☒ 2nd __ 3rd Employment desired: __ Full-Time __ Part-Time

Are you authorized to work in the U.S? ☒ Yes __ No

How did you hear about us? Friends Referral Name: Omat othawa

If under 18, please list age: _____

Do you have responsibilities or commitments that will prevent you from meeting specified work schedules? ☒ No ____ Yes

Education				
Type of School	Name of School	Location (Complete Mailing Address)	Number of Years Completed	Major & Degree
High School	<u>Mavo</u>		<u>4</u>	
College				
Bus. Or Trade School				
Professional School				

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Previous Employment

Company: Charter Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: Call center / picking up phone calls

From: 2015 To: 2016 Reason for Leaving: moved location

May we contact your previous supervisor for reference? ☒ Yes ☐ No

Company: Benchmark Phone: _____

Address: _____ Supervisor: Jim

Job Title: _____ Starting Salary: \$ 13²⁵ Ending Salary: \$ 13²⁵

Responsibilities: worked in a office - shipping office / warehouse

From: 7/17 To: 9/17 Reason for Leaving: Laid off

May we contact your previous supervisor for reference? ☒ Yes ☐ No

Company: Crenio Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: Assembly line - production line worker

From: 3/17 To: 6/17 Reason for Leaving: New Job

May we contact your previous supervisor for reference? ☒ Yes ☐ No

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for reference? ☐ Yes ☐ No

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

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PLEASE READ CAREFULLY APPLICATION FORM WAIVER

In exchange for the consideration of my job application by Corporate Management Group, Inc.,

I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements and the like as they may exist from time to time, or other company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of Corporate Management Group, Inc. (CMG), or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by an officer of CMG. Both the undersigned and CMG may end the employment relationship at any time, without specified notice or reason. If employed, I understand that CMG may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

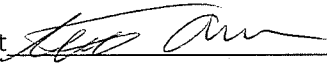
I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination. I hereby give CMG permission to contact schools, all previous employers (unless otherwise indicated), references and others and hereby release CMG from any liability as a result of such contact.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by CMG. 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 CMG policies.

I release CMG and other persons or entities from any claims that might be based on CMG's decision to conduct a background check.

I understand that, in connection with the routine processing of your employment application, CMG may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics and mode of living. Upon written request from me, CMG will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with CMG shall be probationary for a period of ninety (90) days and further that at any time during the probationary period or thereafter, my employment relationship with CMG is terminable at will for any reason by either party.

Signature of applicant  Date: 11-20-17



Preliminary Questions

For CMG use only

Name: Teekawok

Date: 11-20-17

☒ If hired are you willing to take a drug test? yes

☒ Do you have any known food allergies to soy, wheat, peanuts, or milk? no

☒ Are you able to work with pork? yes

☒ Which plant do you prefer? NW

☒ What shift do you prefer? 2nd

To be completed during or after interview

Date of interview 11/20/17

☒ Have you ever been convicted of a crime? Yes _____ No X

Explain

Incident _____

☒ Employee Signature [Signature]

Interviewer Signature [Signature]

Corporate Management Group
Teak Oman's Employment Application

12^{pm}
11/20

Date Submitted: 11/15/2017

Job Title: Reichel Foods Immediate Openings! Apply Today Start Monday!

Job Location: Rochester

ENTERED

Personal Information

First Name: Teak

Last Name: Oman

Email: toman3510@gmail.com

General Information

Contact Information

Cell Phone: 507 517 7980

Home Phone: n/a

**MINNESOTA DRIVER'S LICENSE/ENHANCED DRIVER'S LICENSE
IDENTIFICATION CARD/INSTRUCTION PERMIT APPLICATION
APPLICATION RECEIPT**

THIS IS NOT A STANDALONE IDENTIFICATION DOCUMENT

NECOTA DRIVER'S LICENSE, INSTRUCTION PERMIT OR IDENTIFICATION CARD NUMBER												BIRTH DATE (MONTH/DAY/YEAR)							
1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0
J. LEGAL NAME Tacka Jack												COMPLETE MIDDLE NAME Oman				COMPLETE LAST NAME Oman			
VIOUS LEGAL NAME (ONLY APPLIES IF YOU CHANGED IT SINCE LAST MN DRIVER'S LICENSE, EDL, ID OR IP APPLICATION)																			
COMPLETE FIRST NAME												COMPLETE MIDDLE NAME				COMPLETE LAST NAME			
L RESIDENCE ADDRESS (WHERE YOU LIVE) Note: MAKE SURE THIS IS YOUR CURRENT AND VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD.																			
STREET 3094 7th St NW												APR# 17							
CITY ROCKVILLE												STATE MN				ZIP CODE 56001			
COUNTY Mn County																			
TIONAL MAILING ADDRESS (SEE #1 ON BACK OF WHITE COPY) MAKE SURE THIS IS A VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD. FROM THAT THE U.S. POSTAL SERVICE WILL NOT DELIVER MAIL TO MY RESIDENCE ADDRESS SHOWN ABOVE. INITIAL HERE TO HAVE YOUR CARD SENT TO THE ADDRESS BELOW.																			
NUMBER												STREET				APT#			
TYPE												STATE				ZIP CODE			
EYE COLOR Blue												HEIGHT 6 Ft.				WEIGHT IN POUNDS 190			
PHYSICAL DESCRIPTION Male												SEX MALE				GENDER FEMALE			

Visit dvs.dps.mn.gov to:

- Check the status of your driving privileges
- Schedule a road test

Questions? Contact Us:

Driver's License Questions:	651-297-3298
License Status, available 24/7	651-284-1234
DVS Locations:	651-297-2005
Motor Vehicle Questions:	651-297-2126
TDD/TTY:	651-282-6555

(DV'S USE ONLY) DEPARTMENT OF PUBLIC SAFETY - DRIVER LICENSE DEPARTMENT OF PUBLIC SAFETY - DRIVER LICENSE DEPARTMENT OF PUBLIC SAFETY - DRIVER LICENSE DEPARTMENT OF PUBLIC SAFETY - DRIVER LICENSE DEPARTMENT OF PUBLIC SAFETY - DRIVER LICENSE DEPARTMENT OF PUBLIC SAFETY - DRIVER LICENSE	DATE	11-15-1998
	ISSUE	11-15-1998
	FEES PAID	\$10.00
	TOTAL	\$10.00
	CASH	\$10.00
	NO. OF VEHICLE	1

TYPE ☐ REG ☐ EDL		TESTS PASSED: (STATE EXAM USE ONLY) ☐ D ☐ MC ☐ MBOP ☐ GK ☐ AIR ☐ COMB ☐ DBL/TRIPLE ☐ PASSENGER ☐ SCHOOL BUS ☐ TANKER ☐ HAZMAT ☐ DWI		RESTRICT/ENDORSE ☐ MC ORIGINAL ☐ MC RENEWAL ☐ ADD/REMOVE		VISION ☐ PASS NR ☐ PASS with CL ☐ INCOMPLETE ☐ ATTACHED:	
REG ☐ A ☐ DUP ☐ B ☐ DUP ☐ C ☐ DUP ☐ D ☐ DUP ☐ PROV ☐ DUP ☒ ID ☐ DUP ☐ MBOP ☐ DUP ☐ CLP ☐ REG IP		INDICATORS ☐ SENIOR ☐ LTD MOBILITY ☐ SNOWMOBILE ☐ FIREARM ☐ S or TC ☐ VETERAN		FEES PAID APPLICATION \$ 1.00		PROPER ID ☐ YES ☐ NO 12/20	
		OTHER FEES MC SB PHYS \$ REIN FEE OTHER \$ ORGAN DONATION \$		INVALIDATED (DL/ID / IP) STATE: 06/05/11 EXP:			
NOTES: Duplicate to ID							

I was provided all privacy warnings as required by state and federal law. Submission of this application constitutes consent to registration with the selective service system, if required by federal law. I certify that the information on this application is correct. If I am applying for driving privileges, I am aware of the duties, responsibilities, and penalties outlined in M.S. § 169.444 regarding the safety of children around school buses.

X

Applicant Signature

Application Date

**THIS DOCUMENT IS A RECEIPT FOR THE TYPE OF CARD INDICATED,
AND IS NOT A STANDALONE IDENTIFICATION DOCUMENT**

- This receipt, in conjunction with an invalidated previous license, instruction permit or ID card, may be used as identification.
- This receipt is valid for the type of card indicated, when stamped with the proper validation stamp, for a maximum of 60 days from the application date shown above.
- This receipt is void if the applicant is not in compliance with all restrictions indicated on the driving record.
- **Not valid as Enhanced Driver's License (EDL) for border crossings.**
- **Lost, stolen and duplicate EDL cards are deactivated and may not be used for border crossings.**

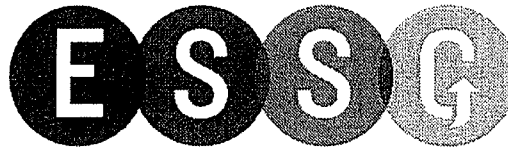


Employee Photo Release Form

I, Terrie Owen, agree to let Reichel Foods use my picture for internal security purposes. I also agree to submit a written request to Reichel Foods if/when I wish my photo be removed from the company database.

Employee Signature: *Terrie Owen*

Date: 11-20-17



employer solutions staffing group, inc.

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Oman First Name Teekajwok Middle Initial O
 Street Address 3094 25th St NW Apt/Ste 12
 City/State/Zip Rochester, MN 55901 Social Security Last Four XXX-XX- 6714
 Phone Number 507-517-7480 Email Address _____ @ _____
 Staffing Agency/Recruitment Partner CMG

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

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

Applicant Certification and Authorization

I authorize Employer Solutions Staffing Group (ESSG) to use the information and statements contained in this application to determine my qualifications for employment. I authorize ESSG to make inquiries of my former employers, except as indicated in this application, regarding my previous duties, responsibilities, performance, compensation and eligibility for rehire.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.

I release ESSG and other persons or entities from any claims that might be based on ESSG's decision to conduct a background check.

I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

If hired, I agree to abide by the policies and procedures of ESSG.

Teekajwok Oman Teekajwok Oman Nov 20, 2017
 Name (Print or type) Applicant's Signature Date

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

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (If applicable) _____	ESC Application _____
For ESSG Client Use				
DOH _____	ROP _____	Work Site Loc. _____	WC Code _____	

EMERGENCY CONTACT INFORMATION

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

Employee Name: Teekajwok Oman

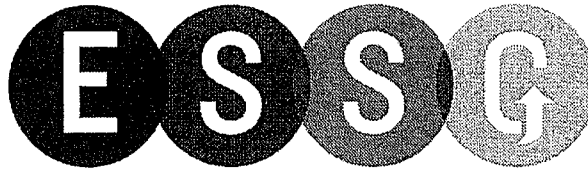
Address: 3094 25th St NW Rochester, MN 55901

Home Phone: 507-517-7480

EMERGENCY CONTACTS	
Please list two people (in priority order) who could be contacted in case of an emergency	
Contact #1 Name: Anna Relationship:	Home Phone: Cell Phone: 507-319-1069 Work Phone:
Contact #2 Name: Relationship:	Home Phone: Cell Phone: Work Phone:

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

This information will remain confidential and will only be used in the case of an emergency.



employer solutions staffing group_{llc}

STATEMENT OF CONFIDENTIALITY

This agreement made this _____ day of _____, 201____, 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.

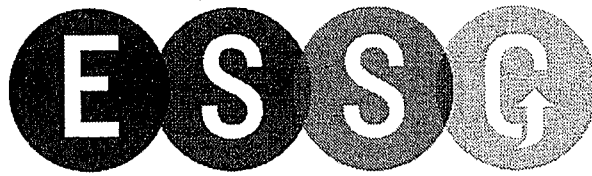
Teekajiwok Oman

Teekajiwok Oman (Nov 20, 2017)

Employee Signature



Employer Solutions Staffing Group LLC, Representative



employer solutions staffing group_{llc}

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.

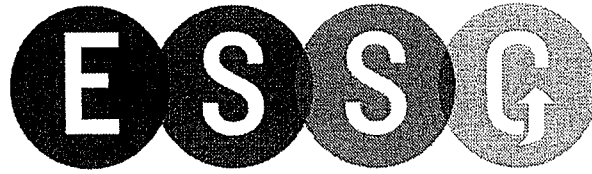
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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: Teekajwok Oman
Teekajwok Oman (Nov 20, 2017)

Printed Name: Teekajwok Oman



employer solutions staffing group_{llc}

Important/Importante

LOST OR STOLEN PAYCHECKS

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

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

CHEQUES DE PAGO PERDIDOS O ROBADOS

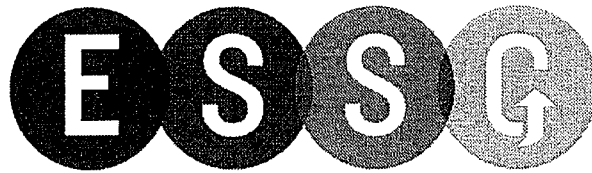
Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted,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

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

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Teekajwok Oman

Signature/Firma: Teekajwok Oman
Teekajwok Oman (Nov 20, 2017)



employer solutions staffing group_{llc}

Acknowledgement of Receipt of Workplace Safety Policy

I certify that I have received a copy of Employer Solutions Staffing Group's ESSG WORKPLACE SAFETY POLICY. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at **952.835.1288/1.866.496.7573** with any questions I may have about this policy. I agree to comply with ESSG's policy on ESSG WORKPLACE SAFETY POLICY and I understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am believe that I am working in an unsafe or dangerous work environment, I will immediately contact my supervisor, manager, director or ESSG's Safety Director at **952.835.1288/1.866.496.7573** in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Teekajwok Oman

Employee's Signature:

Teekajwok Oman

Teekajwok Oman (Nov 20, 2017)

Date: Nov 20, 2017

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

OMB No. 1545-1500

► Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

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

Your name Teekajwok Oman Social security number ► 504-25-6714

Street address where you live 3094 25th St NW

City or town, state, and ZIP code Rochester, MN 55901

County Olmsted Telephone number 507-517-7480

If you are under age 40, enter your date of birth (month, day, year) 12/13/1995

- 1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a. Received SNAP benefits (food stamps) for the past 6 months; **or**
 - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
 - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.
- 7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

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

Job applicant's signature ► Teekajwok Oman
Teekajwok Oman (Nov 20, 2017)

Date Nov 20, 2017

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

First Name: Last Name:	Suffix:	Street Address:	City/State:	Zip:
Teekajwok Oman		3094 25th St NW	Rochester, MN	55901
SS#:	Date of Birth:	Age:	Have you worked for this company before?	If yes, location:
504-25-6714	12/13/1995	21	Yes ☐ No ☒	

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

Yes No

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.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	☐	☒
2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.) Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	☐	☒
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 you checked yes please provide a copy of your SSI documentation.	☐	☒
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 a copy of your DD-214 and letter of separation. (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?	☐	☒
6. Have you been unemployed at any time during the last 12 months? If yes, dates of unemployment - From: _____ To: _____ Did you receive unemployment compensation at any point during your unemployment? If yes, in which state did you receive unemployment compensation? _____	☐	☒
7. 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? If you checked yes please provide a copy of your CDIB 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: Teekajwok OmanDate: Nov 20, 2017

Teekajwok Oman (Nov 20, 2017)



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

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

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

New Hire's Signature: Teekajwok Oman Date Nov 20, 2017
Teekajwok Oman (Nov 20, 2017)

New Hire Name: Teekajwok Oman

Social Security Number: 504-25-6714

Employer Name: CMG/R F

Please check the statements below if they apply to you.

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

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

Privacy Act Notice:

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

Public Burden Statement:

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

**DRUG AND ALCOHOL
TESTING CONSENT FORM**

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

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.



Individual's Name

11-20-17

Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6



SENSITIVE BUT UNCLASSIFIED

Case Verification Number: 2017324133409NX

Report Prepared: 11/20/2017

Company Information

Company ID: 47429

Company Name: Employer Solutions Staffing Group

Employee Information

Last Name: Oman

First Name: Teekajwok

Date of Birth: 12/13/1995

Social Security Number: *** ** 6714

Hire Date: 11/20/2017

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: Minnesota

Driver's License or ID Card Number:

Document Expiration Date: This document has no expiration date

Case Status Information

Current Case Result: Employment Authorized

Employer Case ID:

Case Submitted On: 11/20/2017

Case Submitted By: GLEN7602

SENSITIVE BUT UNCLASSIFIED

MINNESOTA DRIVER'S LICENSE/ENHANCED DRIVER'S LICENSE IDENTIFICATION CARD/INSTRUCTION PERMIT APPLICATION

APPLICATION RECEIPT

THIS IS NOT A STANDALONE IDENTIFICATION DOCUMENT

MINNESOTA DRIVER'S LICENSE, INSTRUCTION PERMIT OR IDENTIFICATION CARD NUMBER: 1248217237419 BIRTH DATE (MONTH/DAY/YEAR): 12/13/1995

LEGAL NAME: JACK JUNK COMPLETE FIRST NAME: JACK COMPLETE MIDDLE NAME: JUNK COMPLETE LAST NAME: JUNK

PREVIOUS LEGAL NAME (ONLY APPLIES IF YOU CHANGED IT SINCE LAST MN DRIVER'S LICENSE, EDL, ID OR IP APPLICATION):

COMPLETE FIRST NAME: COMPLETE MIDDLE NAME: COMPLETE LAST NAME:

RESIDENCE ADDRESS (WHERE YOU LIVE) NOTE: MAKE SURE THIS IS YOUR CURRENT AND VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD.
STREET: 3094 75th ST NW Apt# 117 STATE: MN ZIP CODE: 55412 MN COUNTY: Hennepin

TOTAL MAILING ADDRESS (SEE #1 ON BACK OF WHITE COPY) MAKE SURE THIS IS A VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD.
STREET: Apt# STATE: ZIP CODE: MN COUNTY:

UNDER: STREET: Apt# STATE: ZIP CODE: MN COUNTY:

TY: STREET: Apt# STATE: ZIP CODE: MN COUNTY:

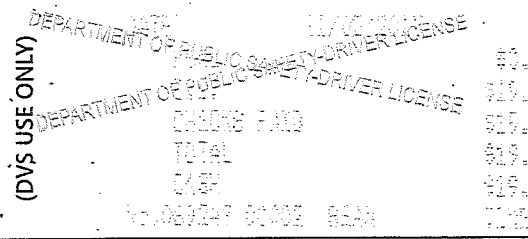
APPLICANT'S PHYSICAL DESCRIPTION: EYE COLOR: b Fr. 6 In. 191 HEIGHT: 6 FT. 6 IN. WEIGHT IN POUNDS: 191 MALE FEMALE: X

Visit dvs.dps.mn.gov to:

- Check the status of your driving privileges
- Schedule a road test

Questions? Contact Us:

Driver's License Questions: 651-297-3298
License/Status, available 24/7 651-284-1234
DVS Locations: 651-297-2005
Motor Vehicle Questions: 651-297-2126
TDD/TTY: 651-282-6555



2017771306045

TYPE ☐ REG ☐ A ☐ B ☐ C ☐ D ☐ PROV ☐ ID ☐ MBOP ☐ CLP ☐ REG IP	EDL ☐ DUP ☐ DUP ☐ DUP ☐ DUP ☐ DUP ☐ DUP ☐ DUP ☐ DUP ☐ DUP	TESTS PASSED (STATE EXAM USE ONLY) ☐ D ☐ MC ☐ MBOP ☐ GK ☐ AIR ☐ COMB ☐ DBL/TRIPLE ☐ PASSENGER ☐ SCHOOL BUS ☐ TANKER ☐ HAZMAT ☐ DWI ☐ RT Passed ☐ RT Waived ☐ S or TC ☐ VETERAN	RESTRICT/ENDORSE ☐ MC ORIGINAL ☐ MC RENEWAL ☐ ADD/REMOVE FEES PAID APPLICATION \$ OTHER FEES \$ MC \$ SB PHYS \$ REIN FEE \$ OTHER \$ ORGAN DONATION \$	VISION ☐ PASS NR ☐ PASS WITH CL ☐ INCOMPLETE ☐ ATTACHED: PROPER ID ☐ YES ☐ NO 12/13/1995	INVALIDATED DL/ID/IP STATE: Exp:
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NOTES:

I was provided all privacy warnings as required by state and federal law. Submission of this application constitutes consent to registration with the selective service system, if required by federal law. I certify that the information on this application is correct. If I am applying for driving privileges, I am aware of the duties, responsibilities, and penalties outlined in M.S. § 169.444 regarding the safety of children around school buses.

X

Applicant Signature

Application Date

THIS DOCUMENT IS A RECEIPT FOR THE TYPE OF CARD INDICATED,
AND IS NOT A STANDALONE IDENTIFICATION DOCUMENT

- This receipt, in conjunction with an invalidated previous license, instruction permit or ID card, may be used as identification.
- This receipt is valid for the type of card indicated, when stamped with the proper validation stamp, for a maximum of 60 days from the application date shown above.
- This receipt is void if the applicant is not in compliance with all restrictions indicated on the driving record.
- Not valid as Enhanced Driver's License (EDL) for border crossings.
- Lost, stolen and duplicate EDL cards are deactivated and may not be used for border crossings.



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)

Last Name (Family Name) Oman		First Name (Given Name) Teekajwok		Middle Initial O	Other Last Names Used (if any) Teak	
Address (Street Number and Name) 3094 25th St NW		Apt. Number 12	City or Town Rochester		State MN	ZIP Code 55901
Date of Birth (mm/dd/yyyy) 12/13/1995	U.S. Social Security Number 504 - 25 - 6714		Employee's E-mail Address		Employee's Telephone Number (507) 517-7480	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

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

☒ 1. A citizen of the United States
☐ 2. A noncitizen national of the United States (See instructions)
☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): N/A
☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): N/A Some aliens may write "N/A" in the expiration date field. (See instructions)
Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.
1. Alien Registration Number/USCIS Number: N/A OR 2. Form I-94 Admission Number: N/A OR 3. Foreign Passport Number: N/A Country of Issuance: N/A
QR Code - Section 1 Do Not Write In This Space 

Signature of Employee 	Today's Date (mm/dd/yyyy) 11-20-17
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Preparer and/or Translator Certification (check one):

☒ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

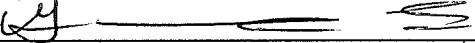
(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name) Oman	First Name (Given Name) Teekajwok	M.I. O	Citizenship/Immigration Status 1
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title N/A		Document Title ID card issued by state/territory		Document Title Social Security Card (Unrestricted)
Issuing Authority N/A		Issuing Authority Minnesota		Issuing Authority Social Security Administration
Document Number N/A		Document Number N/A		Document Number 504256714
Expiration Date (if any)(mm/dd/yyyy) N/A		Expiration Date (if any)(mm/dd/yyyy) N/A		Expiration Date (if any)(mm/dd/yyyy) N/A
Document Title N/A		Additional Information QR Code - Section 2 Do Not Write In This Space 		
Issuing Authority N/A				
Document Number N/A				
Expiration Date (if any)(mm/dd/yyyy) N/A				
Document Title N/A				
Issuing Authority N/A				
Document Number N/A				
Expiration Date (if any)(mm/dd/yyyy) N/A				
Document Title N/A				
Issuing Authority N/A				

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

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

Signature of Employer or Authorized Representative 		Today's Date (mm/dd/yyyy) 11/20/2017		Title of Employer or Authorized Representative Administrative Assistant	
Last Name of Employer or Authorized Representative Lenz		First Name of Employer or Authorized Representative Garrison		Employer's Business or Organization Name ESSG	
Employer's Business or Organization Address (Street Number and Name) 7480 Flying Cloud Drive			City or Town Eden Prairie		State MN
			ZIP Code 55344		

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	_____
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B	_____
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	_____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	_____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	_____
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F	_____
(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)			
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.	G	_____
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶	H	_____
For accuracy, complete all worksheets that apply. • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.			

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

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2017	
▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.					
1 Your first name and middle initial Teekajwok O		Last name Oman		2 Your social security number 504-25-6714	
Home address (number and street or rural route) 3094 25th St NW		3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.			
City or town, state, and ZIP code Rochester, MN 55901		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐			
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5		0	
6 Additional amount, if any, you want withheld from each paycheck		6		\$	
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. if you meet both conditions, write "Exempt" here ▶		7			
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶ <u>Teekajwok Oman</u> Teekajwok Oman (Nov 20, 2017)		Date ▶ Nov 20, 2017			
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)	

**EMPLOYER SOLUTIONS STAFFING GROUP
BACKGROUND CHECK AUTHORIZATION**

Employee Name: Teekajwok Oman
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: 3094 25th St NW Rochester, MN 55901
(Mo/Yr) (Street) (City) (State/Zip)

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

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

Social Security Number: 504-25-6714 DOB: 12/13/1995

Phone Number: 507-517-7480

Driver's License Number/State: _____

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

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

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

Signature: Teekajwok Oman Date: Nov 20, 2017
Teekajwok Oman 11/20/2017

Notice to CA, MN, and OK Residents:

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

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