

CORPORATE MANAGEMENT GROUP



ment Application

rs: 9am-4pm Mon-Fri

ber: 651-666-3883

Address: 404 Broadway Ave St. Paul Park, MN 55071

Applicant Information

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

Please fully complete pages 1-3 ^{8pm}

Full Name: (Last Name, First Name) DeBerry, Trinity Date: 4/11/2017

Address: (Street Address) 183 old 6th st E (Apt./Unit #) _____

(City) Saint Paul (State) MN (ZIP Code) 55101

Phone: 773 829-6280 Email: deberry2768@gmail.com

Social Security No. 319 76 6962 Date Available: 4/11/2017

Position Applied for: production (molding line) Desired Salary: open

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

What is your means of transportation to work? GMC Envoy 2002

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

How did you hear about us? Have worked here before Referral Name: Sophcap

If under 18, please list age: _____

Education				
Type of School	Name of School	Location (Complete Mailing Address)	Number of Years Completed	Major & Degree
High School	South Shore	7529 S. Constance Chicago, IL 60649	4	
College				
Bus. Or Trade School				
Professional School				

CORPORATE MANAGEMENT GROUP

3rd open to start
asap



Employment Application

Office Hours: 9am-4pm Mon-Fri

Office Number: 651-666-3883

Office Address: 404 Broadway Ave St. Paul Park, MN 55071

Your workforce management & staffing experts

Previous Employment

Company: McDonald's Phone: 651 739 0395

Address: 1841 Suburban Ave Supervisor: Carrie

Job Title: Manager Starting Salary: \$ 10 Ending Salary: \$ 13

Responsibilities: Customer Service

From: May 2016 To: - Reason for Leaving: Still there

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

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

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: Trinity DeBerry

Date: 9/11/17

CORPORATE MANAGEMENT GROUP

Employment Application

Office Hours: 9am-4pm Mon-Fri

Office Number: 651-666-3883

Office Address: 404 Broadway Ave St. Paul Park, MN 55071



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

Trinity D. Bentley

Date:

4/11/17



your workforce management & staffing experts

Drug & Alcohol Testing Consent Form for Applicants Who Have Received a Conditional Offer of Employment – MRO

Acknowledgement Receipt

I Acknowledge that I have received a job offer from Corporate Management Group (CMG) conditioned upon my submitting to and passing a drug and alcohol test. I have also received, read and understand Corporate Management Group's Policy and Procedure on an at-will basis and that this policy does not alter the at-will nature of the employment relationship.

I hereby agree to submit to drug and alcohol testing under the Company's policy.

I also understand that test results and other information acquired in the drug and alcohol testing process may be disclosed to and discussed with a Medical Review Offices (MRO). I hereby consent to such test results and other information being disclosed to and discussed with an MRO.

X Date: 4/11/17

X Trinity DeBerry

Employee Signature

X Trinity DeBerry

Employee Name (printed)

Date: 4/11/17

[Signature]

Witness Signature

Garrison Lenz

Witness Name (Printed)

TEST RESULTS RECORD

Test Reference Number MD-56101 Name of Collector _____

COMPANY INFORMATION

Company Name Corporate Management Group Phone 651-666-3883 Fax _____
 Address 400 BROADWAY AVE City ST. PAUL PARK State/Province MN Zip/Postal Code 55071

DONOR INFORMATION

Last Name Deberry Employee I.D. _____
 First Name Trinity
 Type of Identification Provided: Driver's License Employee Photo I.D. Other _____
 Reason for test: Pre-employment Random Reasonable cause Post-accident Other _____

CERTIFICATION

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and alcohol.

X Trinity Deberry Donor signature Date / Time 4/11/17 10am

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge.

[Signature] Collector signature Date / Time 4/11/17 10am

Laboratory signature _____

Date / Time received _____

TEST RESULTS

Date/Time Collected 4/11/17 10am

Time Interpreted 4/11/17 10

NOTE: Lab personnel obtain specimen samples by puncturing the lab extraction ports on the side of device with a needle and syringe and drawing out the sample.

Side of Device



Lab extraction ports

Drug Name	Symbol	Negative	Positive	Not Tested
Alcohol	ALC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine	AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bupranorphine	BUP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepine	BZ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	COC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EDU	EDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M...	...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	MET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opioid	OP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxycodone	OXY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phencyclidine	PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes / Comments _____

Cut out this panel to
 attach to back of report



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) DeBerry		First Name (Given Name) Trinity		Middle Initial D	Other Last Names Used (if any)	
Address (Street Number and Name) 183 Old 6th St E			Apt. Number	City or Town Saint Paul	State MN	ZIP Code 55101
Date of Birth (mm/dd/yyyy) 05/29/1985	U.S. Social Security Number 319-76-6962	Employee's E-mail Address Deberry2768@gmail.com			Employee's Telephone Number 773 829 6280	

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):

<input checked="" type="checkbox"/> 1. A citizen of the United States	QR Code - Section 1 Do Not Write In This Space
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (See instructions) <i>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.</i> 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____	

Signature of Employee <i>Trinity DeBerry</i>	Today's Date (mm/dd/yyyy) 2/11/17
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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 1. Employer or Authorized Representative Review and Verification
 (Employers or their authorized representative must complete and sign Section 1 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 "List of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
-------------------------------------	-------------------------	-------------------------	------	--------------------------------

List A		OR		List B		AND		List C	
Identity and Employment Authorization				Identity				Employment Authorization	
Document Title		Document Title		Document Title		Document Title		Document Title	
Issuing Authority		Issuing Authority		Issuing Authority		Issuing Authority		Issuing Authority	
Document Number		Document Number		Document Number		Document Number		Document Number	
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)	
Document Title		Additional Information				QR Code - Sections 2 & 3 Do Not Write in This Space			
Issuing Authority									
Document Number									
Expiration Date (if any)(mm/dd/yyyy)									
Document Title									
Issuing Authority									
Document Number									
Expiration Date (if any)(mm/dd/yyyy)									

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)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town	State
7480 FLYING CLOUD DRIVE SUITE 200			MINNEAPOLIS	ZIP Code
			MN	55344

Section 2. 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
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MINNESOTA
IDENTIFICATION CARD
NOT A DRIVER'S LICENSE



TRINITY DEON DEBERRY
183 OLD 6TH ST E
ST PAUL, MN 55401

Date of Birth 05-29-1985
Sex M Eyes BLK
Height 6-0 Weight 140
ISSUED 06-2016 EXPIRES 05-29-2020

Trinity DeBerry

K41149517806



SOCIAL SECURITY

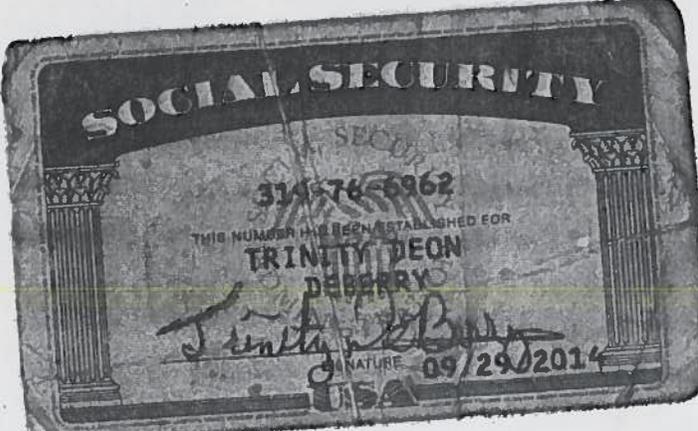
314-78-6962

THIS NUMBER HAS BEEN ESTABLISHED FOR
TRINITY DEON
DEBERRY

Trinity DeBerry

NATURE 09/29/2014

USA





This card belongs to the Social Security Administration and you must return it if we ask for it.

If you find a card that isn't yours, please return it to:

Social Security Administration
P.O. Box 33008 Baltimore, MD 21290-3008

For any other Social Security business information, contact your local Social Security office. If you write to the above address for any business other than returning a found card you will not receive a response.

Social Security Administration
Form SSA-3000 (08-2011)



G42800316



Preliminary Questions

For CMG use only

Name: Trinity

Date: 4/11/17

1. If hired are you willing to take a drug test? Y
2. Do you have any known food allergies to soy, wheat, peanuts, or milk? N
3. Are you able to work with pork? Y

To be completed during or after interview

Have you ever been convicted, plead guilty or contest to a Felony? Yes No

If yes, please list when, where and the nature of the offense(s):

2003
2004

Have you ever been convicted, plead guilty or contest to a Misdemeanor? Yes No

If yes, please list when, where and the nature of the offense(s):

You will not be denied employment solely because you answer "Yes" above or because you have been convicted of a crime, felony or misdemeanor. The company considers many individualized factors in evaluating a job candidate, including but not limited to, with respect to criminal history, the nature and date of any offense, the surrounding circumstances, and the nature of the position for which you apply.

By signature below, I certify that the information provided above is true and complete that I have discussed the above with my interviewer as disclosed. I understand and agree that any misrepresentation by me will be sufficient cause to eliminate me from consideration for employment and/or terminate employment at any time if I have been employed.

Applicant signature: Trinity Berry Date: 4/11/17

Authorization

Authorization: By signing below, you authorize: (a) backgroundchecks.com ("BGC") and/or Orange Tree Employment Screening to request information about you from any public or private information source; (b) anyone to provide information about you to BGC and/or Orange Tree Employment Screening; (c) BGC and/or Orange Tree Employment Screening to provide Employer Solutions Staffing Group, LLC one or more reports based on that information; and (d) Employer Solutions Staffing Group, LLC ("ESSG") to share those reports with others for legitimate business purposes related to your employment. BGC and/or Orange Tree Employment Screening may investigate your education, work history, professional licenses and credentials, references, address history, social security number validity, right to work, criminal record, lawsuits, driving record, credit history, and any other information with public or private information sources. You acknowledge that a fax, image, or copy of this authorization is as valid as the original. You make this authorization to be valid for as long as you are an employee of ESSG.

The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is attached to this authorization. If you are a New York applicant, a copy of New York's law on the use of criminal records is attached. By signing below, you acknowledge receipt of these documents.

Personal Information: Please print the information requested below to identify yourself for BGC.

Printed name: Trinity Deon DeBerry
First Middle (none) Last

Other names used: _____

Current county of residence: _____

Current and former addresses:

_____ current 183 old 6th st e Saint Paul MN 55101
from Mo/Yr to Mo/Yr Street City, State & Zip

_____ to Mo/Yr Street City, State & Zip

_____ to Mo/Yr Street City, State & Zip

Some government agencies and other information sources require the following information when checking for records. BGC will not use it for any other purposes.

05 / 29 / 1985 319 - 76 - 6962
Date of birth Social security number

Driver's license number & state

Name as it appears on license

Report Copy: If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: .

Trinity DeBerry
Signature

4 / 11 / 17
Date

**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

Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6



Authorization for Release of Employment Information

Date:

Case number: 1788434-MA

To:

Worker name: NA Vang

Agency name:

Agency address:

City, state, zip code:

Worker phone: 651 - Fax:

266-4657

We need to verify the employment information for the person listed below:

Person name:

Address:

City/state/zip code: -----

Social Security number: XXX-XX-____

Please provide the information requested on the back of this form and sign the form where indicated. On the bottom half of this form is a signed authorization to release information to the human services agency shown below.

Thank you for your cooperation.

Authorization for Release of Information

Giving Permission: I give permission for the person/organization above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences: State and Federal privacy laws protect my records. I know: -----

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it, unless the law allows for a longer period.

CLIENT SIGNATURE <i>X Ma Wang</i>	DATE XU-11-17	Original copy for agency Provide copy to client
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	

Employment Information

To be completed by employer - return both pages to requesting agency
(Mail or fax to agency address/fax number on first page)

EMPLOYEE NAME MAWAY	SOCIAL SECURITY NUMBER 079-96-6211	CASE NUMBER 1788434
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Employment period:	DATE BEGAN/EXPECTED TO BEGIN	DATE ENDED/EXPECTED TO END	IF ENDED, DATE LAST PAID
REASON ENDED <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	EXPLAIN:		GROSS AMOUNT

Pay rate: <input type="checkbox"/> \$ _____/hour <input type="checkbox"/> \$ _____/day <input type="checkbox"/> \$ _____/acre <input type="checkbox"/> Other (explain: _____)	If per acre, # of acres anticipated? _____ Does this rate depend on the type of work performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____
--	---

Income received/expected: Provide information for these months: _____, _____, _____

What was the date of the first pay check received? _____

EMPLOYMENT IS:	AVERAGE # HOURS PER PAY PERIOD:	HOW OFTEN PAID:
<input type="checkbox"/> Part time <input type="checkbox"/> Full time	_____	<input type="checkbox"/> Each week <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> End of job <input type="checkbox"/> Other _____

Work Schedule:

SUN	MON	TUES	WED	THUR	FRI	SAT

Attach verification of income earned, itemized by pay period, or complete the table below.
 Note: For future months, anticipate income.

Date received	Income received (Record only those wages which you are reasonably certain the employee will be paid.)						
Gross earnings							
No. of hours worked							
Advances/Tips/Bonuses							
Child Support withheld							
Medical insurance							

Medical insurance:

Does the employee have medical insurance through you or your company? Yes No

Is medical insurance available through you or your company? Yes No

If yes, what is the employee cost? \$ _____ per _____ (period of coverage)

Signature of employer: _____

I understand that the information provided on this form is correct to the best of my knowledge. I understand that this form is not a contract for services.

EMPLOYER SIGNATURE	COMPANY/BUSINESS NAME	
FEIN	PHONE NUMBER	DATE