



SENSITIVE BUT UNCLASSIFIED

**Case Verification Number: 2017201145339GW**  
Report Prepared: 07/20/2017

**Company Information**

Company ID: 47428

Company Name: Employer Solutions Staffing Group

**Employee Information**

Last Name: weatherspoon

Date of Birth: 07/31/1985

Hire Date: 07/20/2017

First Name: paul

Social Security Number: \*\*\* \*\* 8421

Citizenship Status: A citizen of the United States

**Document Information**

List B Document: ID card issued by a U.S. federal, state or local government agency

List C Document: U.S. birth certificate (original or certified copy)

**Case Status Information**

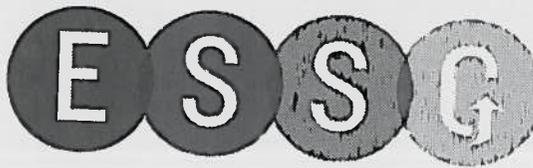
Current Case Result: Employment Authorized

Case Submitted On: 07/20/2017

Employer Case ID:

Case Submitted By: SGLA8882

SENSITIVE BUT UNCLASSIFIED



employer solutions staffing group

# New Hire Application

Personal Data-- **PLEASE PRINT LEGIBLY IN INK**

Last Name WEATHERSPOON First Name PAUL Middle Initial J.  
 Street Address 1261 Selby Ave Apt/Ste N/A  
 City/State/Zip SAINT PAUL PARK MN 55111 Social Security Last Four XXX-XX-5421  
 Phone Number 651 459 6968 Email Address PaulWeather Spoon@gmail.com  
 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.

Paul Joseph Weather Spoon  
Name (Print or type)

Paul J. Weather Spoon  
Applicant's Signature

07-20-2017  
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<br>_____ | Background Release Form<br>_____ | Background Results<br>_____ | Unemployment Letter<br>(If applicable)<br>_____ | ESC Application<br>_____ |
| For ESSG Client Use             |                                  |                             |                                                 |                          |
| DOH _____                       | ROP _____                        | Work Site Loc. _____        | WC Code _____                                   |                          |

# 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 this 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 1992, 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](http://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 | <u>1</u> |
| B | Enter "1" if:<br><ul style="list-style-type: none"> <li>• You're single and have only one job; or</li> <li>• You're married, have only one job, and your spouse doesn't work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>                                                                                                                                                                                                                                                  | B | <u>1</u> |
| C | Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .                                                                                                                                                                                                                                                                                                                                   | C | <u>0</u> |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                                             | D | <u>0</u> |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . . .                                                                                                                                                                                                                                                                                                                                                                                                                             | E | <u>0</u> |
| F | Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) . . . . .                                                                                                                                                                                                                                                                                                                  | F | <u>0</u> |
| G | <b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.<br><ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> | G | <u>0</u> |
| H | Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶                                                                                                                                                                                                                                                                                                                                                                                                                 | H | <u>2</u> |

For accuracy, complete all worksheets that apply.   
 • 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.   
 • 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 <b>W-4</b><br>Department of the Treasury<br>Internal Revenue Service                                                                                                                                                                                                                                                                                                                                    | <h2>Employee's Withholding Allowance Certificate</h2> <p>▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p> | OMB No. 1545-0074<br><h1 style="font-size: 2em;">2017</h1>                                                                                                                                                                                                |
| Your first name and middle initial: <b>PAUL J.</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                      | Last name: <b>WEATHERSPOON</b>                                                                                                                                                                                                                            |
| Home address (number and street or rural route): <b>1261 Selby Ave</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                      | 2 Your social security number: <b>471-06-5421</b>                                                                                                                                                                                                         |
| City or town, state, and ZIP code: <b>SAINT PAUL PARK MN 55071</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                      | 3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate.<br>Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                      | 5 <u>2</u>                                                                                                                                                                                                                                                |
| 6 Additional amount, if any, you want withheld from each paycheck                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                      | 6 \$ <u>0</u>                                                                                                                                                                                                                                             |
| 7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption.<br>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and<br>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.<br>If you meet both conditions, write "Exempt" here. |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                           |
| Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                           |
| Employee's signature (This form is not valid unless you sign it.)<br>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                      | Date: <b>07-20-2017</b>                                                                                                                                                                                                                                   |
| 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)                                                                                                                                                                                                                   |



**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)<br><b>WEATHERSPOON</b>             |  | First Name (Given Name)<br><b>PAUL</b>             |                          | Middle Initial<br><b>J</b>                                    | Other Last Names Used (if any)<br><b>N/A</b> |                                                    |
| Address (Street Number and Name)<br><b>1261 Selby Ave.</b> |  |                                                    | Apt. Number<br><b>NA</b> | City or Town<br><b>SAINT PAUL PARK</b>                        |                                              | State<br><b>MN</b>                                 |
| Date of Birth (mm/dd/yyyy)<br><b>07-31-1985</b>            |  | U.S. Social Security Number<br><b>4711-06-5421</b> |                          | Employee's E-mail Address<br><b>PJWeather Spoon@gmail.com</b> |                                              | ZIP Code<br><b>55071</b>                           |
|                                                            |  |                                                    |                          |                                                               |                                              | Employee's Telephone Number<br><b>651-459-6968</b> |

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): \_\_\_\_\_

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)

*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: \_\_\_\_\_  
 OR  
 2. Form I-94 Admission Number: \_\_\_\_\_  
 OR  
 3. Foreign Passport Number: \_\_\_\_\_

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

QR Code - Section 1  
 Do Not Write In This Space

Signature of Employee *Paul J. Weather Spoon* Today's Date (mm/dd/yyyy) **07-20-2017**

**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.")*

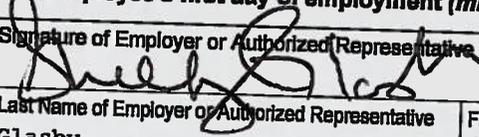
|                              |                                                |                                        |                  |                                |
|------------------------------|------------------------------------------------|----------------------------------------|------------------|--------------------------------|
| Employee Info from Section 1 | Last Name (Family Name)<br><b>Weatherspoon</b> | First Name (Given Name)<br><b>Paul</b> | M.I.<br><b>J</b> | Citizenship/Immigration Status |
|------------------------------|------------------------------------------------|----------------------------------------|------------------|--------------------------------|

List A      OR      List B      AND      List C  
 Identity and Employment Authorization      Identity      Employment Authorization

|                                      |                                                                                                                                          |                                                    |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| Document Title                       | Document Title<br><b>MN ID</b>                                                                                                           | Document Title<br><b>Birth Cert</b>                |
| Issuing Authority                    | Issuing Authority<br><b>State of MN</b>                                                                                                  | Issuing Authority<br><b>State of MN</b>            |
| Document Number                      | Document Number<br><b>Q887134760023</b>                                                                                                  | Document Number<br><b>1985-MN</b>                  |
| Expiration Date (if any)(mm/dd/yyyy) | Expiration Date (if any)(mm/dd/yyyy)<br><b>10-11-2017</b>                                                                                | Expiration Date (if any)(mm/dd/yyyy)<br><b>N/A</b> |
| Document Title                       | Additional Information                                                                                                                   |                                                    |
| Issuing Authority                    |                                                                                                                                          |                                                    |
| Document Number                      |                                                                                                                                          |                                                    |
| Expiration Date (if any)(mm/dd/yyyy) |                                                                                                                                          |                                                    |
| Expiration Date (if any)(mm/dd/yyyy) |                                                                                                                                          |                                                    |
| Document Title                       | QR Code - Section 2<br>Do Not Write In This Space<br> |                                                    |
| Issuing Authority                    |                                                                                                                                          |                                                    |
| Document Number                      |                                                                                                                                          |                                                    |
| Expiration Date (if any)(mm/dd/yyyy) |                                                                                                                                          |                                                    |
| 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): **07-20-2017** (See instructions for exemptions)

|                                                                                                                                           |                                                                      |                                                                                   |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------|
| Signature of Employer or Authorized Representative<br> | Today's Date (mm/dd/yyyy)<br><b>07-20-2017</b>                       | Title of Employer or Authorized Representative<br><b>Recruiter</b>                |                          |
| Last Name of Employer or Authorized Representative<br><b>Glasby</b>                                                                       | First Name of Employer or Authorized Representative<br><b>Shelby</b> | Employer's Business or Organization Name<br><b>Employer Solution Staffing Gro</b> |                          |
| Employer's Business or Organization Address (Street Number and Name)<br><b>7480 Flying Cloud Drive Suite 200</b>                          | City or Town<br><b>Eden Prairie</b>                                  | State<br><b>MN</b>                                                                | ZIP Code<br><b>55344</b> |

**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 |
|----------------------------------------------------|---------------------------|-----------------------------------------------|

STATE OF MINNESOTA  
CERTIFICATION OF VITAL RECORD

CERTIFICATE OF BIRTH

STATE FILE NUMBER 1985-MN-039737

FULL NAME PAUL JOSEPH WEATHERSPOON  
DATE OF BIRTH JULY 31, 1985  
SEX MALE  
PLACE OF BIRTH MINNEAPOLIS HENNEPIN MINNESOTA  
PARENT CYNTHIA ANN  
NAME AT BIRTH SMITH

ANY AMENDMENT MADE PRIOR TO 08/09/2000 FOR THIS RECORD IS NOT NOTED ON THIS CERTIFICATE.

THIS IS A TRUE AND CORRECT RECORD OF BIRTH REGISTERED IN THE MINNESOTA OFFICE OF THE STATE REGISTRAR.

MR&C Certificate ID  
7626421



000838985

FILED: AUGUST 15, 1985

*Steve Elkins*

STEVE ELKINS  
STATE REGISTRAR

ISSUED: APRIL 27, 2012

HENNEPIN COUNTY SERVICE CENTER-GC

THIS CERTIFICATION IS VALID ONLY WHEN REPRODUCED ON WATERMARKED SECURITY PAPER  
WITH A RAISED BORDER AND RAISED STATE SEAL OF MINNESOTA.



**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: **Q867134760673**

BIRTH DATE (MONTH/DAY/YEAR): **07/31/98**

FILED LEGAL NAME: **Paul Joseph Weatherston**

COMPLETE FIRST NAME: **Paul**

COMPLETE MIDDLE NAME: **Joseph**

COMPLETE LAST NAME: **Weatherston**

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: \_\_\_\_\_

FULL RESIDENCE ADDRESS (WHEN YOU LIVE) NOTE: MAKE SURE THIS IS YOUR CURRENT AND VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD.

Number: **1261** Street: **Delroy Avenue** Apt# \_\_\_\_\_

City: **Saint Paul Park** State: **MN** Zip Code: **55071** MN COUNTY: **WASH.**

OPTIONAL MAILING ADDRESS (SEE #1 ON BACK OF WHITE COPY) MAKE SURE THIS IS A VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD. I AFFIRM 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# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ MN COUNTY: \_\_\_\_\_

APPLICANT'S PHYSICAL DESCRIPTION

EYE COLOR: **BK N** HEIGHT: **5** FT. **08** IN. WEIGHT IN POUNDS: **149**

MALE  FEMALE

Visit [dvs.dps.mn.gov](http://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

(DVS USE ONLY)

**PAID**

**JUL 11 2017**

**Deputy 107**

2017704192000

VISION

PASS NR

PASS with CL

INCOMPLETE

ATTACHED:

PROPER ID

YES  NO

RESTRICT/ENDORSE

MC ORIGINAL

MC RENEWAL

ADD/REMOVE

FEES PAID APPLICATION

\$ **14.75**

OTHER FEES

MC \$ \_\_\_\_\_ SB PHYS \$ \_\_\_\_\_

REIN FEE \$ \_\_\_\_\_ OTHER \$ \_\_\_\_\_

ORGAN DONATION \$ \_\_\_\_\_

INVALIDATED

DL: **10A** / IP

STATE: \_\_\_\_\_

EXP: **2019**

TYPE

REG

EDL

A

B

C

D

PROV

FIELD

MBOP

CLP

REG IP

TESTS PASSED (STATE EXAM USE ONLY)

D

MC

MBOP

GK

AIR

COMB

DBL/TRIPLE

PASSENGER

SCHOOL BUS

TANKER

HAZMAT

INDICATORS

SENIOR

LTD MOBILITY

SNOWMOBILE

FIREARM

S or TC

VETERAN

NOTES: **Lost / COA**

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.

Applicant Signature: *[Signature]*

Application Date: **7/17**

**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.

MINNESOTA DEPARTMENT OF PUBLIC SAFETY  
MINNESOTA DRIVER'S LICENSE/IDENTIFICATION CARD APPLICATION  
TENNESSEN WARNING

**IMPORTANT: READ THIS NOTICE BEFORE  
YOU COMPLETE THE APPLICATION**

**NOTICE**

Why are you being asked to share this information and how will it be used?

The Department of Public Safety (DPS) will use the information to identify you as a person, to identify your driving record, to determine your eligibility for a driver's permit, license or identification card, prevent fraud, to access your record for any future service transactions and/or inquiries, and to comply with state and federal laws.

State and federal laws require collection of this information.

Minnesota Statutes §§ 171.06, 221.031, and 221.0314, and federal motor carrier safety regulations (49 C.F.R. §§ 383.71 and 383.153) require collection of this information.

Consequences of supplying or refusing to supply requested information.

If you supply the requested information, DPS will be able to determine whether to issue you a driver's permit, license, or identification card. The information may be used by other states to make decisions about whether to issue you a driver license, permit, or identification card. The requested information may also be used by insurance providers to determine eligibility for automobile insurance coverage. If you don't provide the information requested, DPS cannot issue you a driver's permit, license, or identification card, and your existing driving privileges, if any, may be affected.

How is the requested information shared with other agencies?

DPS releases this information to local, state, and federal government agencies only as authorized or required by state and federal law. This means that the information may be shared with the following:

- Social Security Administration
- Selective Service System
- Federal Department of Labor
- MN Department of Human Services
- MN Department of Revenue
- MN Department of Commerce
- MN Attorney General's Office
- MN Office of the Secretary of State
- MN Department of Natural Resources
- MN Department of Veterans Affairs

In addition, your personal information may be disclosed as authorized by United States Code, title 18, section 2721.

A note about your Social Security number.

You must provide your Social Security number according to M.S. § 171.06 and the Social Security Act, 42 U.S.C. § 656(e) (13). Your Social Security number is also required to determine your eligibility for a commercial driver's license under federal motor carrier safety regulations, 49 C.F.R. § 383.153. It is used to administer child support enforcement programs and locate individuals to establish paternity. It is also used to confirm your identity and residential address with the Social Security Administration, the Minnesota Department of Revenue, the Internal Revenue Service, Minnesota Department of Natural Resources, and the Minnesota Department of Human Services.

**PERMISSIBLE USES OF MOTOR VEHICLE DATA AS PROVIDED IN  
UNITED STATES CODE, TITLE 18, SECTION 2721**

For use by any government agency, including any court or law enforcement agency, in carrying out its functions, or any private person or entity acting on behalf of a federal, state, or local agency in carrying out its functions.

For use in connection with matters of motor vehicle or driver safety and theft; performance monitoring of motor vehicle product alterations, recalls, or advisories; vehicle market research activities, including survey research, and removal of non-owner records from the original owner records of motor vehicle manufacturers.

For use in the normal course of business by a legitimate business or its agents, employees, or contractors, but only:

- (A) to verify the accuracy of personal information submitted by the individual to the business or its agencies, employees, or contractors; and
- (B) if such information as so submitted is not correct or is no longer correct, to obtain correct information, but only for the purposes of preventing fraud by, pursuing legal remedies against, or recovering on a debt or security interest against, the individual.

For use in connection with any civil, criminal, administrative, or arbitral proceeding in any federal, state, or local court or agency or before any self-regulatory body, including the service or process, investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, or pursuant to an order of a federal, state, or local court.

For use in research activities, and for use in producing statistical reports, so long as the personal information is not published, re-disclosed, or used to contact individuals.

For use by any insurer or insurance support organization, or by a self-insured entity, or its agents, employees, or contractors, in connection with claims investigation activities, anti-fraud activities, rating, or underwriting.

For use in providing notice to the owners of towed or impounded vehicles.

For use by any licensed private investigative agency or licensed security service for any purpose permitted under this subsection.

For use by an employer or its agent or insurer to obtain or verify information relating to a holder of a commercial driver's license that is required under the Commercial Motor Vehicle Safety Act, 49 U.S.C. §§ 31301-17.

For use in connection with the operation of private toll transportation facilities.

For any other use in response to requests for individual motor vehicle records if the state has obtained the express consent of the person to whom such personal information pertains.

For bulk distribution for surveys, marketing, or solicitations if the state has obtained the express consent of the person to whom such personal information pertains.

For use by any requester, if the requester demonstrates it has obtained the written consent of the individual to whom the information pertains.

For any other use specifically authorized under the law of the state that holds the record, if such use is related to the operation of a motor vehicle or public safety.

**MINNESOTA**  
**IDENTIFICATION CARD**  
**NOT A DRIVER'S LICENSE**

PAUL JOSEPH WEATHERSPOON  
1261 SELBY AVE  
ST PAUL PARK, MN 55071

Date of Birth 07-31-1986  
Sex Eyes Class  
M BRN ID  
Height Weight DONOR  
5-8 160

ISSUED 01-2015 EXPIRES 07-31-2016

Q887134760023

social security  
471-06-5421

# EMERGENCY CONTACT INFORMATION

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

Employee Name: PAUL JOSEPH WEATHERSPOON  
Address: 1261 SELBY AVE. SAINT PAUL PARK MN 5507  
Home Phone: 651-459-6968

### EMERGENCY CONTACTS

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

| EMERGENCY CONTACTS                                                                        |                                                                                                       |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| Please list two people (in priority order) who could be contacted in case of an emergency |                                                                                                       |
| <b>Contact #1</b><br>Name: <u>Cynthia Ann Kath</u><br>Relationship: <u>Mother</u>         | Home Phone: <u>651 459 6968</u><br>Cell Phone: <u>651-324-5716</u><br>Work Phone: <u>651-324-5716</u> |
| <b>Contact #2</b><br>Name:<br>Relationship:                                               | Home Phone:<br>Cell Phone:<br>Work Phone:                                                             |

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

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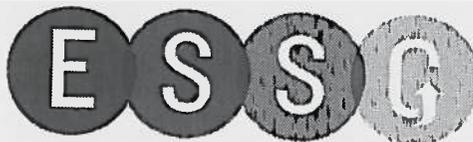
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*This information will remain confidential and will only be used in the case of an emergency.*



employer solutions staffing group, Inc.

### Wage Payment Method Authorization (Minnesota)

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 paper Check.

#### SECTION 1 BASIC INFORMATION

|                                                  |                                            |                                     |
|--------------------------------------------------|--------------------------------------------|-------------------------------------|
| Employee Name<br><b>PAUL JOSEPH WEATHERSPOON</b> | SSN# (last 4 digits)<br><b>471-06-5421</b> | Effective Date<br><b>07-20-2017</b> |
|--------------------------------------------------|--------------------------------------------|-------------------------------------|

#### SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below) *Note: Direct Deposit accounts may take up to 7 days to be activated*

Payroll Debit Card (Please complete Sections 4 and 5 below)  Paper Check (Please complete Section 5 below)

#### SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: \_\_\_\_\_

Routing#: \_\_\_\_\_

Account#: \_\_\_\_\_

Account Type:  Checking  Savings  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 \_\_\_\_\_ Date \_\_\_\_\_

- To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work)
- If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

#### 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<br><b>PAUL</b>                                       | M.I.<br><b>J</b>   | Last Name<br><b>WEATHERSPOON</b> | Date of Birth<br><b>07-31-1985</b>         |
| Street Address (PO BOX NOT ACCEPTABLE)<br><b>1261 Selby Ave</b> |                    |                                  | Social Security#<br><b>471-06-5421</b>     |
| City<br><b>SAINT PAUL PARK</b>                                  | State<br><b>MN</b> | Zip<br><b>55071</b>              | Cell Phone (mobile)<br><b>651 404 9859</b> |

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

|                                                  |                                                            |
|--------------------------------------------------|------------------------------------------------------------|
| Payroll Debit Card Routing #<br><b>073972181</b> | Payroll Debit Card Account #<br><b>4853 4004 0399 7242</b> |
|--------------------------------------------------|------------------------------------------------------------|

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: *Paul J Weather Spoon*

Date: 07-20-2017

#### 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: PJWeather Spoon @ Gmail . com  
this information will only be used to send your paystubs electronically

Employee's Signature: *Paul J Weather Spoon*

Date: 07-20-2017

## 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:

PAUL  
First

JOSEPH  
Middle (  
none)

WEATHERSPOON  
Last

Other names used: \_\_\_\_\_

Current county of residence: \_\_\_\_\_

Current and former addresses:

\_\_\_\_\_ current \_\_\_\_\_  
from Mo/Yr to Mo/Yr Street City, State & Zip

\_\_\_\_\_ \_\_\_\_\_  
from Mo/Yr to Mo/Yr Street City, State & Zip

\_\_\_\_\_ \_\_\_\_\_  
from Mo/Yr 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.

\_\_\_\_\_ Date of birth

\_\_\_\_\_ Social security number

\_\_\_\_\_ Driver's license number & state

\_\_\_\_\_ Name as it appears on license

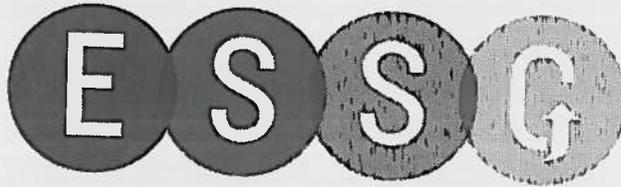
**Report Copy:** If you are applying for a job or live in California, Minnesota, or Oklahoma, you may request a copy of the report by checking this box: .

Signature

*Paul J. Weather Spoon*

Date

07-20-2017



employer solutions staffing group<sub>llc</sub>

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**STATEMENT OF CONFIDENTIALITY**

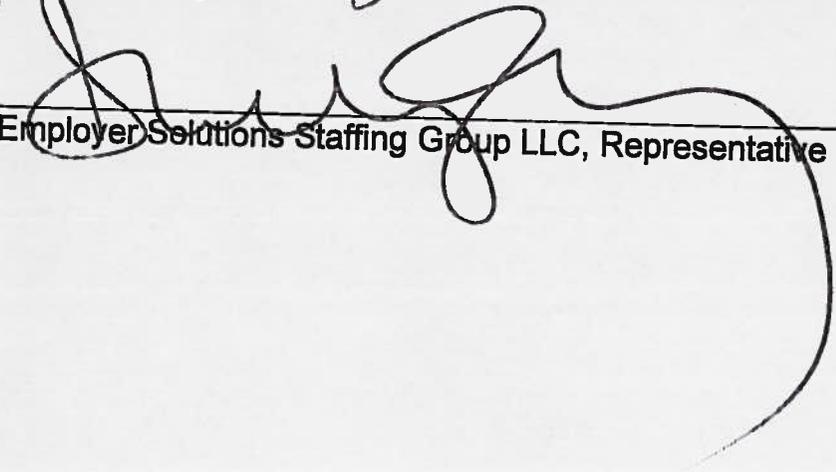
This agreement made this 19<sup>th</sup> day of July, 2017 between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Paul J. Wetherspan hereafter referred to as "employee".

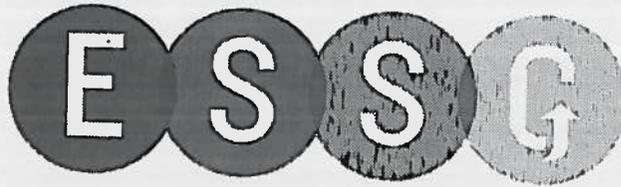
**WITNESSETH:**

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

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

  
\_\_\_\_\_  
Employee Signature

  
\_\_\_\_\_  
Employer Solutions Staffing Group LLC, Representative



employer solutions staffing group, c.

## 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 police 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): Paul Joseph Weatherspoon

Signature/Firma: Paul J. Weatherspoon

# 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](http://www.irs.gov/form8850).

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

Your name Paul Joseph Weatherspoon Social security number ▶ 471-06-5421

Street address where you live 1261 Selby Ave

City or town, state, and ZIP code Saint Paul Park MN 55071

County Washington Telephone number 651-959-6968

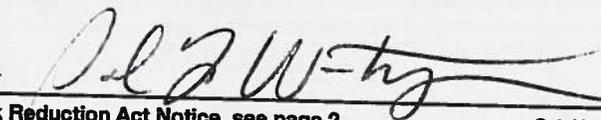
If you are under age 40, enter your date of birth (month, day, year) 07-31-1985

- 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 6 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 ▶



Date 07-20-2017

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 22851L

Form **8850** (Rev. 3-2016)

**EMPLOYER SECTION:**

|                  |  |                  |                          |
|------------------|--|------------------|--------------------------|
| <b>Client:</b>   |  | <b>Company:</b>  |                          |
| <b>Location:</b> |  | <b>Position:</b> | <b>Starting Wage: \$</b> |

**EMPLOYEE SECTION:**

|                         |                                  |                |                                                                                                                        |                                       |                   |
|-------------------------|----------------------------------|----------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------|
| <b>First Name:</b> Paul | <b>Last Name:</b> Weatherspoon   | <b>Suffix:</b> | <b>Street Address:</b> 1261 Selby Ave                                                                                  | <b>City/State:</b> Saint Paul Park MN | <b>Zip:</b> 55071 |
| <b>SS#:</b> 471-06-5421 | <b>Date of Birth:</b> 07-31-1985 | <b>Age:</b> 31 | <b>Have you worked for this company before?</b><br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | <b>If yes, location:</b>              |                   |

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yes                      | No                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| <p><b>1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?</b> (If yes, please provide information below.)<br/>                     Name of the person receiving benefits: _____ Relationship to you: _____<br/>                     City: _____ County: _____ State: _____</p>                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?</b> (If yes, please provide information below.)<br/>                     Name of the person receiving benefits: _____ Relationship to you: _____<br/>                     City: _____ County: _____ State: _____</p>                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?</b><br/>                     Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits.<br/>                     *If you checked yes please provide a copy of your SSI documentation.</p>                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>4. Have you received any type of vocational rehabilitation services within the past two years?</b><br/>                     If yes, please indicate which type of agency you worked with and provide their location information below:<br/> <input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> Employment Network (Ticket to Work Program)<br/>                     Name of Agency: _____ Phone #: _____<br/>                     City: _____ County: _____ State: _____<br/>                     *If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.</p> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>5. Are you a Veteran of the U.S. Military?</b> *If yes, please provide a copy of your DD-214 and letter of separation.<br/>                     (If yes, please provide information below. If no, please continue to question #6.)<br/>                     Dates of Service - From: _____ To: _____<br/>                     Branch of Service: _____<br/>                     Are you entitled to or are you receiving compensation for a service-connected disability?</p>                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>6. Have you been unemployed at any time during the last 12 months?</b><br/>                     If yes, dates of unemployment - From: _____ To: _____<br/>                     Did you receive unemployment compensation at any point during your unemployment?<br/>                     If yes, in which state did you receive unemployment compensation? _____</p>                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>7. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</b><br/>                     Conviction Date: _____ Release Date: _____<br/>                     Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____</p>                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Additional Tax Credits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |                          |
| <p><b>IEC (Native American):</b> Are you or your spouse a member of a Native American Tribe?<br/>                     If you checked yes please provide a copy of your CDIB card.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>CA Residents:</b> <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act?<br/> <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?</p>                                                                                                                                                                                                                                                                                                                                                                |                          |                          |
| <p><b>SC Residents:</b> <input type="checkbox"/> Do you receive Family Independence Benefits?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                          |

**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: Paul J. Weatherspoon

Date: 07-20-2017



**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: Paul J. Weatherspoon Date 07-20-2017  
New Hire Name: Paul J. Weatherspoon  
Social Security Number: 471-06-5421  
Employer Name: CMG

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.

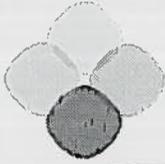
I declare that I have been in a period of unemployment since 02/2017.  
(Enter start date)

**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.



# employer solutions staffing group<sup>LLC</sup>

Leveraging Resources in a Changing Market

## Notification of Minnesota Law Requirement – Unemployment Acknowledgement

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

It is your responsibility to contact ESSG (for instance, by calling 952.277.5227 or using any other form of contact) for additional assignments. If you fail to do so, it may affect your unemployment benefits.

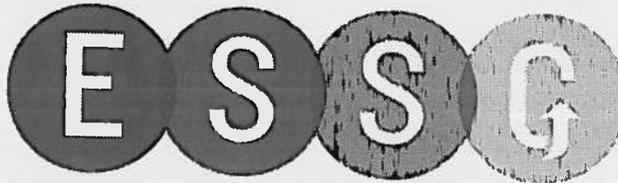
I understand by signing this form that I am responsible to contact ESSG within 5 calendar days once an assignment ends. I also acknowledge that I have received a separate copy of this form. *PJW* (Initial)

*Paul J. Weatherspan*  
Employee Signature:

Date:

*07-20-2017*

*Paul J. Weatherspan*  
Employee (please print your name here)



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### 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.

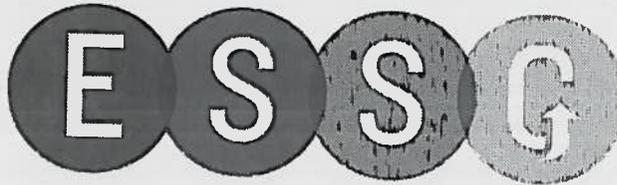
Employee Name (Please Print)

Paul Joseph Weatherspoon

Employee's Signature:

Paul J. Weatherspoon

Date: 07-20-2017



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## **ESSG WORKPLACE SAFETY POLICY**

It is ESSG's policy that all employees should be able to enjoy a hazard free and safe work environment. It is ESSG's duty to:

- (1) Ensure that its clients provide you with a workplace free from serious recognized hazards and comply with standards, rules and regulations issued under the OSH Act.
- (2) Ensure that its clients perform a job hazard assessment in order to identify and eliminate potential safety and health hazards and to determine necessary training and protections for employees at the facility.
- (3) Make sure employees have and use safe tools and equipment.
- (4) Establish or update operating procedures and communicate them so that employees follow safety and health requirements.
- (5) Provide safety training in a language and vocabulary workers can understand.

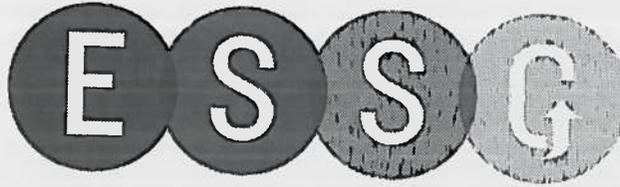
ESSG is committed to vigorously enforcing its OSHA Compliance Policy.

To help ensure a safe workplace, you have certain responsibilities too, which include the following:

- Responsibility to work in compliance with OSHA laws and regulations
- Responsibility to use personal protective equipment and clothing as directed by the host employer
- Responsibility to report workplace hazards and dangers
- Responsibility to work in a manner as required by the employer and use the prescribed safety equipment.

You have the following basic rights:

- Right to refuse unsafe work
- Right to know or be informed about actual and potential dangers in the workplace
- Right to review copies of appropriate standards, rules, regulations and requirements that the host employer is required to have available at the workplace.



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## **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:

Paul J. Weather Spoon

Printed Name:

Paul Joseph Weatherspoon

**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.

Paul Joseph Weatherspoon  
Individual's Name

07-20-2017  
Date

**SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6**

# Enhanced MEC Plan\_Plan 1

**Benefits Enrollment Form**

New Employee            Rehire            Rehire Date           

**Employee Information**

|                                                                                 |                                                                                                                              |                                              |                          |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------|
| Name (First and Last)<br><b>Paul Weatherspoon</b>                               |                                                                                                                              | Social Security Number<br><b>471 06 5421</b> |                          |
| Address<br><b>1261 Selby Ave</b>                                                |                                                                                                                              | City<br><b>Saint Paul Park MN</b>            | State<br><b>MN</b>       |
| Gender<br><input checked="" type="radio"/> Male<br><input type="radio"/> Female | Marital Status<br><input checked="" type="radio"/> Single<br><input type="radio"/> Married<br><input type="radio"/> Divorced | Date of Birth<br><b>07-31-1985</b>           | Zip Code<br><b>55071</b> |
| Phone Number:                                                                   |                                                                                                                              | Email Address:                               |                          |
|                                                                                 |                                                                                                                              | <b>07-20-2017</b>                            |                          |

**Please Select Desired Coverage:**

Employee Only - \$24.00/Week   
  Employee+Spouse - \$38.00/Week   
  Employee+Child(ren) - \$36.00/Week   
  Family - \$63.00/Week

**Dependent**

|            |      |           |                   |            |                       |                                                     |
|------------|------|-----------|-------------------|------------|-----------------------|-----------------------------------------------------|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex<br>Male<br>Female | Relationship<br>Spouse<br>Child<br>Domestic Partner |
|            |      |           |                   |            |                       |                                                     |

**Dependent**

|            |      |           |                   |            |                       |                                                     |
|------------|------|-----------|-------------------|------------|-----------------------|-----------------------------------------------------|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex<br>Male<br>Female | Relationship<br>Spouse<br>Child<br>Domestic Partner |
|            |      |           |                   |            |                       |                                                     |

**Dependent**

|            |      |           |                   |            |                       |                                                     |
|------------|------|-----------|-------------------|------------|-----------------------|-----------------------------------------------------|
| First Name | M.I. | Last Name | Social Security # | Birth Date | Sex<br>Male<br>Female | Relationship<br>Spouse<br>Child<br>Domestic Partner |
|            |      |           |                   |            |                       |                                                     |

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

|           |
|-----------|
| EFF. DATE |
|           |
| EFF. DATE |
|           |
| EFF. DATE |
|           |

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

**IF ENROLLING - YOU MUST SIGN HERE**

Employee Signature *Paul W. Weatherspoon* Date 07-20-2017

**EMPLOYEES DECLINING I am DECLINING coverage**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

**IF DECLINING- YOU MUST SIGN HERE**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

# Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION \_\_\_\_\_ Rehire Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.1

**A. REQUIRED EMPLOYEE INFORMATION** **PRINT USING BLACK or BLUE INK (Must Be Filled Out)**

Name Paul J. Weatherspoon Social Security # 411-06-5421 Home Phone 651 959 6968 Sex  M  F  
 Address 1261 Selby Ave Apt. # \_\_\_\_\_  
 City Saint Paul Park State MN Zip 55071 Date of Birth 07/31/1985

**B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?**  Yes  No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) \_\_\_\_\_ Medicare Effective Date \_\_\_\_\_  
 Name of Covered Person (s):  
 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**C. LIMITED BENEFITS PLAN SELECTION** **Payroll Deducted Weekly Rates**

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

| SELECT COVERAGE LEVEL                             | FIXED INDEMNITY MEDICAL <sup>1</sup>                                | DENTAL                                                              | VISION                                                              | TERM LIFE                                                           | SHORT-TERM DISABILITY <sup>2</sup>                                  |
|---------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
| Employee Only <input checked="" type="checkbox"/> | \$20.25 <input checked="" type="checkbox"/>                         | \$6.17 <input checked="" type="checkbox"/>                          | \$2.42 <input checked="" type="checkbox"/>                          | \$0.60 <input checked="" type="checkbox"/>                          | \$4.20 <input checked="" type="checkbox"/>                          |
| Employee + 1 <input type="checkbox"/>             | \$41.10                                                             | \$12.34                                                             | \$4.92                                                              | \$0.90                                                              |                                                                     |
| Employee + Family <input type="checkbox"/>        | \$54.88                                                             | \$20.36                                                             | \$6.56                                                              | \$1.80                                                              |                                                                     |
| NO to ALL Benefits <input type="checkbox"/>       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

<sup>1</sup>This coverage is not available to residents of NH, HI, or PR. <sup>2</sup>STD is not available to persons who work in CA, HI, NJ, NY, or RI.

**For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information. Accidental Death & Dismemberment is part of the Term Life Benefit.**

Name Archite Weatherspoon IV Relationship Sibling

**D. REQUIRED DEPENDENT INFORMATION**

|      |                   |               |                                                       |                                                                                                          |
|------|-------------------|---------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| Name | Social Security # | Date of Birth | Sex                                                   | Relationship                                                                                             |
|      |                   | / /           | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
| Name | Social Security # | Date of Birth | Sex                                                   | Relationship                                                                                             |
|      |                   | / /           | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
| Name | Social Security # | Date of Birth | Sex                                                   | Relationship                                                                                             |
|      |                   | / /           | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |
| Name | Social Security # | Date of Birth | Sex                                                   | Relationship                                                                                             |
|      |                   | / /           | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner |

**E. REQUIRED SIGNATURE** **YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE**

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

DATE 07/20/2017 SIGNATURE Paul J. Weatherspoon