

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

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

Employee Last Name, First Name and Middle Initial from Section 1: Baker, William G

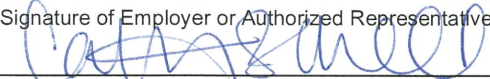
| List A<br>Identity and Employment Authorization | OR | List B<br>Identity                                  | AND | List C<br>Employment Authorization                   |
|-------------------------------------------------|----|-----------------------------------------------------|-----|------------------------------------------------------|
| Document Title:                                 |    | Document Title:<br>Driver License                   |     | Document Title:<br>Social Security Card              |
| Issuing Authority:                              |    | Issuing Authority:<br>Colorado                      |     | Issuing Authority:<br>Social Security Administration |
| Document Number:                                |    | Document Number:<br>12-198-0845                     |     | Document Number:<br>524-99-3020                      |
| Expiration Date (if any)(mm/dd/yyyy):           |    | Expiration Date (if any)(mm/dd/yyyy):<br>05/23/2017 |     | Expiration Date (if any)(mm/dd/yyyy):                |
| Document Title:                                 |    |                                                     |     |                                                      |
| Issuing Authority:                              |    |                                                     |     |                                                      |
| Document Number:                                |    |                                                     |     |                                                      |
| Expiration Date (if any)(mm/dd/yyyy):           |    |                                                     |     |                                                      |
| Document Title:                                 |    |                                                     |     |                                                      |
| Issuing Authority:                              |    |                                                     |     |                                                      |
| Document Number:                                |    |                                                     |     |                                                      |
| Expiration Date (if any)(mm/dd/yyyy):           |    |                                                     |     |                                                      |

3-D Barcode  
Do Not Write in This Space

## 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): 08/24/2015 (See instructions for exemptions.)

|                                                                                                                                          |                                    |                                                                            |                   |
|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------|-------------------|
| Signature of Employer or Authorized Representative<br> | Date (mm/dd/yyyy)<br>08/24/2015    | Title of Employer or Authorized Representative<br>Administrative Assistant |                   |
| Last Name (Family Name)<br>Scholl                                                                                                        | First Name (Given Name)<br>Caitlin | Employer's Business or Organization Name<br>Corporate Management Group     |                   |
| Employer's Business or Organization Address (Street Number and Name)<br>12000 N. Washington Street Suite 350                             | City or Town<br>Thornton           | State<br>CO                                                                | Zip Code<br>80241 |

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

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

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

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



**Affirmation of Legal Work Status**  
Pursuant to § 8-2-122, Colorado Revised Statutes

Employee Name: Baker William G. 5-3-96  
Last First Middle Date of Birth

Social Security Number: 524 - 99 - 3020 Date of Hire: \_\_\_\_\_

In accordance with § 8-2-122, C.R.S., within twenty days after hiring the new employee listed above,

**I affirm all four of the following:**

1. I have examined the legal work status of the above named employee.
2. I have retained file copies of the documents required by 8 U.S.C. sec. 1324a.
3. I have not altered or falsified the employee's identification documents.
4. I have not knowingly hired an unauthorized alien.

Print Name of Employer (or Designated Representative) \_\_\_\_\_ Official Title \_\_\_\_\_

Signature of Employer (or Designated Representative) \_\_\_\_\_ Date Signed \_\_\_\_\_

Corporate Management Group 12000 N. Washington Street #290  
Thornton, CO 80241

303-920-1425

Business or Organization Name \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

§ 8-2-122(2), C.R.S.: On and after January 1, 2007, within twenty days after hiring a new employee, each employer in Colorado shall affirm that the employer has examined the legal work status of such newly-hired employee and has retained file copies of the documents required by 8 U.S.C. sec. 1324a; that the employer has not altered or falsified the employee's identification documents; and that the employer has not knowingly hired an unauthorized alien. The employer shall keep a written or electronic copy of the affirmation, and of the documents required by 8 U.S.C. sec. 1324a, for the term of employment of each employee.

This affirmation and the documents required by 8 U.S.C. sec. 1324 (copies or electronic copies) will be retained for the duration of the above named individual's employment.

This affirmation is provided as a courtesy by the Colorado Division of Labor.



## Authorization of Direct Deposit

The undersigned (hereafter referred to as the "employee") hereby authorizes and requests PAYCOM to make deposits from time to time in the account(s) identified below and authorizes the bank to accept such deposits. It is agreed that these deposits may be made electronically and under the Rules of the National Automated Clearing House Association. It is agreed that PAYCOM is only responsible for direct deposit of funds that have previously been received from \_\_\_\_\_ hereafter referred to as the "employer".

**Attach a voided check, copy of a check, or spec sheet for each account. Indicate whether it is a checking or savings account. (No deposit slips)**

1. Call your bank and confirm the **ACH Routing Number(s)** and Account numbers for **Checking and/or Savings**
2. Complete and Sign the form

**Main Account (Net Pay) - Checking or Savings Account (circle one)**

Acct # \_\_\_\_\_

ACH Routing # / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ /

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

**Additional Account - Checking or Savings Account (circle one)**

Acct # \_\_\_\_\_ Dollar Amount \_\_\_\_\_

ACH Routing # / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ /

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

**Additional Account - Checking or Savings Account (circle one)**

Acct # \_\_\_\_\_ Dollar Amount \_\_\_\_\_

ACH Routing # / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ /

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

**Additional Account - Checking or Savings Account (circle one)**

Acct # \_\_\_\_\_ Dollar Amount \_\_\_\_\_

ACH Routing # / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ /

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

**Additional Account - Checking or Savings Account (circle one)**

Acct # \_\_\_\_\_ Dollar Amount \_\_\_\_\_

ACH Routing # / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ / \_ /

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

**Employee Name** \_\_\_\_\_ **SS#** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

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



**To:** All Employees

**Quien:** Todos Empleados

**From:** Corporate Management Group & Employer Solutions Group

**De:** Corporate Management Group y Employer Solutions Group

**Re:** Stop Payment Check Fee

**Re:** Tarifa de cheque parado

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Effective immediately, to replace a lost or stolen check, \$50.00 will be deducted from the replacement check for a stop payment fee and for a reprocessing fee. *Efectivo inmediatamente, para reemplazar un cheque de sueldo perdido o robado, \$50.00 de tarifa sera deducido de el cheque reemplazado para parar el cheque original y para procesarlo denuevo.*

If you lose your check, we will first have to verify that it has not been processed through the bank. If it has not, a new check will be issued, minus the \$50.00 fee. *Si usted pierde su cheque, tendremos que verificar que no ha sido procesado en el banco. Si no, un cheque nuevo sera processado, menos las tarifa de \$50.00.*

If your check is stolen, we will first need a copy of the police report before a new check can be reissued. After we receive a copy of the police report, a new check will be issued following the same procedures as listed above. *Si su cheque es robado, necesitaremos una copia de el reporte de policia antes de que un cheque nuevo sera procesado. Despues de obtener una copia del reporte de policia, un cheque nuevo sera procesado usando los mismos procedimientos mencionados arriba.*

If you have any questions regarding this new policy, please contact your On-Site Representative or the Corporate Office (303-920-1425). *Si usted tiene preguntas sobre esta poliza, por favor contacte a su representante de CMG o la oficina corporal al (303-920-1425)*

Thank you for your continued dedication and hard work!

*Gracias por su dedicacion continua!*

By signing below you are confirming that you understand the above policy.  
*Con su firma abajo usted esta confirmando que entiende la poliza descrita.*

Signature/Firma: William Barr  
Date/Fecha: 2-24-15

February 2011



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

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

It is your responsibility to contact or notify CMG once your assignment ends. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact or notify CMG once an assignment ends. I also acknowledge that I have received a separate copy of this form.

WB (Initial)

William Baker  
Employee Signature:

8-24-15  
Date:

William Baker  
Employee (please print your name here)



## ANTI-HARASSMENT POLICY

It is Corporate Management Group's (CMG) policy that all employees should be able to enjoy a work environment free from all forms of discrimination, including harassment. As such, CMG is committed to vigorously enforcing their Anti-harassment Policy. This policy applies to all employees of the organization (without regard to position) and individuals not directly connected to CMG (e.g., an outside vendor, consultant, customer or guest). Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, creed, religion, national origin, sex, marital status, status with regard to public assistance, membership or activity in a local commission, disability, sexual orientation or veteran status. Harassment is considered a form of discrimination and is specifically included among the prohibitions under Title VII of the Civil Rights Act of 1964. In addition, retaliation or reprisal taken against anyone who has expressed concern about harassment or discrimination against the individual raising the concern is illegal.

The Equal Employment Opportunity Commission (EEOC) defines sexual harassment as "unwelcome sexual advances, requests for sexual favors, sexual comments, or other verbal or physical acts of a sexual or sex-based nature including, but not limited to drawings, pictures, jokes, and/or teasing where (1) submission to such conduct is made either explicitly or implicitly a term or a condition of an individual's employment; (2) an employment decision is based on an individual's acceptance or rejection of such conduct; or (3) such conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment."

The Anti-harassment Policy prohibits harassment and/or retaliation by any individual employed by, doing business with or for, or visiting CMG. Employees who believe they have been the subject of harassment and/or retaliation or an employee who may have been witness to harassment and/or retaliation must report the incident immediately. Information and/or allegations must be reported to a manager of CMG (**by telephoning 866.920.1425 or 303.920.1425**). Only those who have an immediate need to know, including the alleged target of harassment or retaliation, the alleged harassers or retaliators, and any witnesses may find out the identity of the complainant. All individuals contacted in the course of an investigation will be advised that all persons involved in a charge are entitled to respect and that any retaliation or reprisal against an individual who is an alleged target of harassment or retaliation, who has made a complaint, or who has provided information in connection with a complaint, is a separate violation of CMG's policy. All information will be disclosed only on a need-to-know basis to allow CMG to

investigate and resolve the incident. CMG recognizes the serious nature of harassment and therefore will endeavor to protect the employee who may have been subjected to harassment, any witnesses and the party against whom allegations have been filed to every possible extent.

Harassment is unlawful and has a negative impact on employees. Violation of the Anti-harassment Policy will not be tolerated by CMG and may result in discipline up to and including termination. Offensive acts or conduct have no legitimate business purpose; accordingly, any employee, regardless of his/her position within CMG, who it is determined has engaged in such conduct will be made to bear the full responsibility for such unlawful conduct.

With respect to sexual harassment, the following is prohibited:

1. Unwelcome sexual advances, request for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, especially where:
  - ☐ Submission to such conduct is made either explicitly or implicitly a term or condition of employment;
  - ☐ Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or
  - ☐ Such conduct has the purpose or effect of creating an intimidating, hostile or offensive working environment.
2. Offensive comments, jokes, innuendoes and other sexually-oriented statements.

**If Harassment Occurs:**

1. When possible, confront the harasser and tell him/her to stop. Sometimes a simple confrontation will end the situation.
2. If confrontation is unsuccessful, immediately contact your CMG supervisor to report the harassment.
3. An investigation will be conducted and appropriate action taken, including disciplinary measures. We will investigate, in confidence; all reported incidents of harassment and retaliation.

Employee Signature: William Brown

Date: 8-24-15



**Employees:**

Implementation of the Affordable Care Act (ACA) of 2010 (the health care reform law) requires that we send you this notice. The notice describes the new online Health Insurance Marketplace (also called an Exchange), which is available at [www.healthcare.gov](http://www.healthcare.gov) beginning October 1, 2013. The Marketplace describes options you may have available for health insurance (other than employer-based plans) and is designed so you can make easy cost and coverage comparisons. The enclosed notice also includes information about coverage you may be eligible for through Corporate Management Group (CMG).

If you have coverage through Essential StaffCare, please be advised that the Essential StaffCare plan does not meet the criteria to avoid a penalty under the ACA plan requirements for 2014 and beyond.

Starting in 2014, if you do not have medical coverage, you will have to pay a penalty (in the form of a tax). If you do not qualify for coverage through CMG or you do not enroll yourself or a dependent, it is your responsibility to obtain coverage or pay the penalty. This penalty is known as the "individual mandate penalty."

The individual mandate penalty increases each year. In 2014 the penalty is 1% of your household yearly income or \$95 per adult and \$47.50 per child (up to \$285 for a family), whichever is higher. In 2015 the penalty is 2% of your household yearly income or \$325 per adult and \$162.50 per child (up to \$975 for a family), whichever is higher. The penalty for 2016 is 2.5% of your household yearly income or \$695 per adult and \$347.50 per child (up to \$2,085 for a family), whichever is higher. **If you chose to pay the penalty you will not get any health insurance coverage and will be 100% responsible for the cost of your medical care.**

If you are considered to be low income, Medicaid could be a viable option. Some states will also be expanding the eligibility rule and income requirements to qualify for Medicaid. To determine if the state where you live is expanding Medicaid coverage and to learn about Medicaid, please visit <https://www.healthcare.gov/do-i-qualify-for-medicaid>.

Please remember that open enrollment in the Marketplace begins on **October 1, 2013** and ends on March 31, 2014. After open enrollment ends you will not be able to get health coverage through Marketplace until the **next annual enrollment period**, unless you have a qualifying life event.

Thank you,

**Corporate Management Group**  
303-920-1425  
[Pay@corpmgmtgroup.com](mailto:Pay@corpmgmtgroup.com)





# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(expires 11-30-2013)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.<sup>1</sup>

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

<sup>1</sup> An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

|                                                               |                |                                                       |  |
|---------------------------------------------------------------|----------------|-------------------------------------------------------|--|
| 3. Employer name<br>Corporate Management Group, Inc.          |                | 4. Employer Identification Number (EIN)<br>20-1535646 |  |
| 5. Employer address<br>12000 N. Washington Street, Suite #290 |                | 6. Employer phone number<br>303-920-1425              |  |
| 7. City<br>Thornton                                           | 8. State<br>CO | 9. ZIP code<br>80241                                  |  |
| 10. Who can we contact at this job?<br>Corporate office       |                |                                                       |  |
| 11. Phone number (if different from above)                    |                | 12. Email address<br>Pay@corpmgmtgroup.com            |  |

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

**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 William Baker Social security number ► 524-99-3020  
Street address where you live 5288 E 129<sup>th</sup> Ave.  
City or town, state, and ZIP code Thornton, CO, 80241  
County Adams Telephone number 720-635-8251  
If you are under age 40, enter your date of birth (month, day, year) 5-3-96

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

**Signature—All Applicants Must Sign**

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

Job applicant's signature ► William Baker

Date 8-24-15

**For Employer's Use Only**Employer's name Corporate Management Group Telephone no. 303-920-1425 EIN ▶ 201535646Street address 12000 N Washington St #290City or town, state, and ZIP code Thornton, CO 80241

Person to contact, if different from above \_\_\_\_\_ Telephone no. \_\_\_\_\_

Street address \_\_\_\_\_

City or town, state, and ZIP code \_\_\_\_\_

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under Members of Targeted Groups in the separate instructions), enter that group number (4 or 6) . . . . . ▶ \_\_\_\_\_

Date applicant:

|                     |       |                    |       |              |       |                |       |
|---------------------|-------|--------------------|-------|--------------|-------|----------------|-------|
| Gave<br>information | _____ | Was<br>offered job | _____ | Was<br>hired | _____ | Started<br>job | _____ |
|---------------------|-------|--------------------|-------|--------------|-------|----------------|-------|

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶

Title

Date

## Privacy Act and Paperwork Reduction Act Notice

*Section references are to the Internal Revenue Code.*

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

**Recordkeeping** . . . 6 hr., 27 min.

**Learning about the law or the form** . . . . . 30 min.

**Preparing and sending this form to the SWA** . . . . . 37 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:M:S, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224.

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.

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**SENSITIVE BUT UNCLASSIFIED**

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**Department of Homeland Security**  
**E-Verify****Report Prepared: 08/24/2015**  
**Page: 1 of 1**

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**Case Verification Number: 2015236172004JF****Case Information:**

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**Employee Information:**

|                         |                                |                   |            |
|-------------------------|--------------------------------|-------------------|------------|
| Last Name:              | Baker                          | First Name:       | William    |
| Middle Initial:         | G                              | Other Names Used: |            |
| Social Security Number: | *** ** 3020                    | Date of Birth:    | 05/03/1996 |
| Citizenship Status:     | A citizen of the United States | Email Address:    |            |

**Document Information:**

|                                     |                                                                           |                           |                      |
|-------------------------------------|---------------------------------------------------------------------------|---------------------------|----------------------|
| List B Document:                    | Driver's license or ID card issued by a U.S. state or outlying possession | List C Document:          | Social Security Card |
| Document Name:                      | Driver's license                                                          | Document State:           | Colorado             |
| Driver's License or ID Card Number: |                                                                           | Document Expiration Date: | 05/23/2017           |
| Alien Number:                       |                                                                           | I-94 Number:              |                      |

**Additional Information:**

|                        |            |                         |            |
|------------------------|------------|-------------------------|------------|
| Hire Date:             | 08/24/2015 | Employer Case ID:       |            |
| Three-Day Rule Reason: |            | Three-Day Rule - Other: |            |
| Submitted By:          | CSCH1918   | Submitted On:           | 08/24/2015 |

**Initial Case Result:**

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Case Result: Employment Authorized

**Employee Referred to SSA:**

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Referred By: Referred On:

**Case Result from SSA (after SSA Tentative Nonconfirmation):**

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Case Result: Response Date:

**Resubmitted to SSA (after Review and Update Employee Data):**

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|                         |                   |
|-------------------------|-------------------|
| Last Name:              | First Name:       |
| Middle Initial:         | Other Names Used: |
| Social Security Number: | Date of Birth:    |
| Resubmitted By:         | Resubmitted On:   |

**Case Result from SSA (after Resubmission):**

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Case Result:

**Request Name Review:**

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|               |               |
|---------------|---------------|
| Comments:     |               |
| Submitted By: | Submitted On: |

**Case Result from DHS (after DHS Verification in Process):**

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Case Result: Response Date:

**Employee Referred to DHS:**

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Referred By: Referred On:

**Case Result from DHS (after DHS Tentative Nonconfirmation):**

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Case Result: Response Date:

**Photo Matching Results:**

Determination:

**Employee Referred to DHS (Additional):**

Referred By:

Referred On:

**Case Result from DHS (after Additional DHS Tentative Nonconfirmation):**

Case Result:

Response Date:

**Case Closure:**

Closure Statement:

Closed By:

Closed On:

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**SENSITIVE BUT UNCLASSIFIED**