

employer solutions staffing group.

Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405

Edina, MN 55439

Tel: 952.835.1288 • Fax: 952.835.1255

www.esgstaffingsolutions.com

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Ear First Name Allison Middle Initial N.

Street Address 2012 E. 134th way Apt/Ste _____

City/State/Zip Thornton, CO 80241

Phone Number 720-226-5390 Email Address allisonear@hotmail.com

Company/Employer Accellant

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.

Allison Ear Allison 7/22/14
Name (Print or type) Applicant's Signature Date

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

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

Form W-4 (2013)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

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

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding 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. 508 for information on converting your other credits into withholding allowances.

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

- A Enter "1" for yourself if no one else can claim you as a dependent **A 1**
- B Enter "1" if:
 - You are single and have only one job; or
 - You are married, have only one job, and your spouse does not work; or
 - Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.
- C Enter "1" for your spouse. But, you may choose to enter "0" if you are married and have either a working spouse or more than one job. (Entering "0" may help you avoid having too little tax withheld.) **B**
- D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return **C**
- E Enter "1" if you will file as head of household on your tax return (see conditions under **Head of household** above) **D**
- F Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) **E**
- G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
 - If your total income will be less than \$65,000 (if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children.
 - If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child **G**
- H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ **H 1**

For accuracy, complete all worksheets that apply.

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

Form W-4 Department of the Treasury Internal Revenue Service	Employee's Withholding Allowance Certificate OMB No. 1545-0074 2013	2 Your social security number 522-93-3958	3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
1 Your first, name and middle initial Allison N. Ear	Last name Ear	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>	5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) 5
Home address (number and street or rural route) 2012 E. 134th way	City or town, state, and ZIP code Thornton, CO 80241	6 Additional amount, if any, you want withheld from each paycheck 6 \$	7 I claim exemption from withholding for 2013, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here. ▶ 7
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.			
Employee's signature (This form is not valid unless you sign it.) ▶ <i>Allison Ear</i>		Date ▶ 07/22/14	
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)	

This form cannot be used for employees hired prior to September 6, 2012.



Revision Date: 09/06/12
Expiration Date: 10/01/14

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

Employee Name: Ear Alison N 6/4/94
Last First Middle Date of Birth

Social Security Number: 522 - 93 - 3958 Date of Hire: 7/21/2014
(MM/DD/YYYY)

In accordance with § 8-2-122, C.R.S., within 20 days after hiring the new employee listed above,

I affirm all four of the following by signing this form:

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 by Employer
(MM/DD/YYYY)

Business or Organization Name Employer Phone Number

The provision of false or fraudulent information on this form may subject the employer to a significant fine and/or additional penalties.

This form 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.

§ 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.



Employment Eligibility Verification

USCIS
Form I-9

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

OMB No. 1615-0047
Expires 03/31/2016

▶ START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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) Ear		First Name (Given Name) Allison		Middle Initial N.	Other Names Used (if any)	
Address (Street Number and Name) 2012 E. 134th way			Apt. Number	City or Town Thornton	State CO	Zip Code 80241
Date of Birth (mm/dd/yyyy) 06/04/1994		U.S. Social Security Number 527-93-3958	E-mail Address allisonear@hotmail.com			
		Telephone Number 720-226-5590				

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):

- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (See instructions)

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

- 1. Alien Registration Number/USCIS Number: _____
- OR
- 2. Form I-94 Admission Number: _____

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

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

Signature of Employee: *Allison* Date (mm/dd/yyyy): **07/22/2014**

3-D Barcode
Do Not Write in This Space

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

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

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

STOP Employer Completes Next Page **STOP**



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:

List A OR List B AND List C
Identity Employment Authorization

Document Title:	Document Title:
Issuing Authority:	Issuing Authority:
Document Number:	Document Number:
Expiration Date (if any)(mm/dd/yyyy):	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): _____ (See instructions for exemptions.)

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

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):
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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:
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EMERGENCY CONTACT INFORMATION

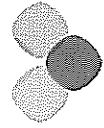
EMPLOYER SOLUTIONS STAFFING GROUP
IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION

Employee Name: Allison Ear
Address: 2012 E. 134th way
Home Phone: 720-226-5390

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

Contact #1 Name: <u>Isabel Ear</u> Relationship: <u>Mother</u>	Home Phone: Cell Phone: <u>303-910-5787</u> Work Phone:
Contact #2 Name: <u>Alex Kim</u> Relationship: <u>Step dad</u>	Home Phone: Cell Phone: <u>720-266-8278</u> 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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Direct Deposit/Payroll Debit Card Authorization

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

SECTION 1 BASIC INFORMATION

Employee Name Allison Ear	SSN# (last 4 digits) 3958	Effective Date
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SECTION 2 PAYROLL ELECTION

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

SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: Bank of the West

Routing# 107002147

Account# 024916452

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 AE Date 7/22/14

- 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 then sign acknowledgement wages.

ALLISON EAR
2012 E 134TH WAY
THORNTON, CO 80241 1387

CARDHOLDER First Name VOID DATE 90-78/1211

Street Address (ORDER OF) _____ \$ _____

City _____ DOLLARS



GET TEXT AL All we need to k RECEIPT OF

Payroll Debit C 122242

I have received m I am agreeing to l 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.

Microchip Card, substitution. I

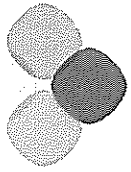
Employee's Signature: _____ Date: _____

SECTION 5 AUTHORIZATION

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

*E-mail: Allisonear@hotmail.com this information will only be used to send your pay stubs electronically

Employee's Signature: Allison Date: 7/22/14



employer solutions staffing group^{llc}

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STATEMENT OF CONFIDENTIALITY

This agreement made this 22 day of July, 2014, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Allison Ear 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.

Allison Ear

Employee Signature

Employer Solutions Staffing Group LLC, Representative

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

OMB No. 1545-1500

▶ See separate instructions.

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.Your name Allison EarSocial security number ▶ 522-93-3958Street address where you live 2012 E. 134th wayCity or town, state, and ZIP code Thornton, CO 80241County Adams Telephone number 720-226-5590If you are under age 40, enter your date of birth (month, day, year) 06/04/1994

- 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 ▶ Allison EarDate 07/22/14

EMPLOYER SECTION:

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

EMPLOYEE SECTION:

Employee Name: <u>Allison Ear</u>	Street Address: <u>2012 E. 13th way</u>	City/State: <u>Thornton CO</u>	Zip: <u>80241</u>
SS#: <u>522-93-3958</u>	Date of Birth: <u>06/04/1994</u>	Age: <u>20</u>	Have you worked for this company before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

Yes No

1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.)
 Name of the person receiving benefits: Isabel Ear Relationship to you: Mother
 City: Thornton County: Hollands State: CO Yes No

2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.)
 Name of the person receiving benefits: Isabel Ear Relationship to you: Mother
 City: Thornton County: Hollands State: CO Yes No

3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits. *If you checked yes please provide a copy of your SSI documentation.
 Yes No

4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below:
 Vocational Rehabilitation Agency Dept. of Veterans Affairs Employment Network (Ticket to Work Program)
 Name of Agency: _____ Phone #: _____
 City: _____ County: _____ State: _____
 *If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation. Yes No

5. Are you a Veteran of the U.S. Military? *If yes, please provide a copy of your DD-214 and letter of separation. (If yes, please provide information below. If no, please continue to question #6)
 Dates of Service - From: ___/___/___ To: ___/___/___
 Branch of Service: _____
 Are you entitled to or are you receiving compensation for a service-connected disability? Yes No
 Have you been unemployed at any time during the last 12 months?
 If yes, dates of unemployment - From: ___/___/___ To: ___/___/___ Yes No
 Did you receive unemployment compensation at any point during your unemployment? Yes No

6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?
 Conviction Date: ___/___/___ Release Date: ___/___/___
 Was this a Federal or State conviction? If State - County: _____ State: _____ Yes No

Additional Tax Credits

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

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

PLEASE READ, SIGN, AND DATE:

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

New Employee Signature: Alison Ear Date: 7/22/14

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.

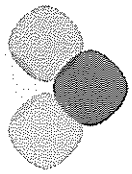
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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: 

Printed Name: Allison Ear



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Important/Importante

LOST OR STOLEN PAYCHECKS

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

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

CHEQUES DE PAGO PERDIDOS O ROBADOS

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

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

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde):

Allison Ear

Signature/Firma:

EMPLOYEE INFORMATION
(Must Be Filled Out)

ENROLLMENT FORM - PLAN 2

USE BLACK or BLUE INK ONLY
ESC.CU(NAV*SAD) P2.V13.0

Social Security Number 522-93-3958

Date of Birth 06/04/1994 Sex M F

Name Allison Ear

Street Address 2672 E. 134th way

City Thousand State CO Zip 80241

Home Phone 720-226-5390

Do you or any dependents have Medicare?

Yes No If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date / /

Names of Covered Person(s)

1. _____

2. _____

3. _____

BENEFIT SELECTION

Weekly Rates

MEDICAL



\$20.91 Employee Only

\$42.44 Employee + One

\$56.67 Employee + Family

NO to MEDICAL, TERM LIFE, and STD benefits.

DENTAL



\$ 5.99 Employee Only

\$11.98 Employee + One

\$19.77 Employee + Family

NO

TERM LIFE



YES \$0.60 Employee Only

\$0.90 Employee + One

\$1.80 Employee + Family

NO

SHORT-TERM DISABILITY



YES

\$4.20 Employee Only

NO

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

You MUST enroll in the Medical Insurance Plan before adding Term Life or STD. Your coverage level for Term Life will be identical to your medical plan selection.

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number _____

Date of Birth / / Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth / / Sex M F

Relationship: Spouse Child Domestic Partner

Name _____

Social Security Number _____

Date of Birth / / Sex M F

Relationship: Spouse Child Domestic Partner

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY

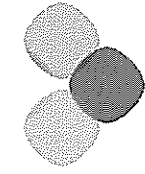
RELATIONSHIP

Accidental Death & Dismemberment is part of the Term Life Benefit.

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.

Signature Allison Ear

Date 07/22/2014



employer solutions staffing group^{uc}

Leveraging Resources in a Changing Market

Notification of Colorado Law Requirement – Unemployment Acknowledgement

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

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

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

Employee Signature:

Allison Ear

Employee (please print your name here)

07/22/14

Date:



12000 N. Washington St. Ste. 290
Thornton, CO. 80241
Phone – 866.920.1425
Fax – 303.736.7767

Background Screening Request – Corporate Management Group

Accellent Package

Submitted by Irene Rival

Return Fax Number: (303) 736-7767

This fax contains the following:

- Authorization form
- Resume

Notes: Please limit the search to the following criteria

- Social Security Trace
- County Criminal History Search - 7 years of address history
- Instant Nationwide
- State Sex Offender
- Education Verification

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

_____, or any of its subsidiaries may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history (State and Federal records), social security verification, address trace, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised NationSearch LLC, 11160 Huron St. Suite 100 Northglenn, Co 80234, (800)-827-9550 will be conducting the ICR or another outside organization. The scope of this notice and authorization is all encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, credit reporting agency, employer, to provide any and all background information requested by NationSearch LLC, 11160 Huron St. Suite 100 Northglenn, CO 80234 (800)-827-9550, another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

Notice to California Applicants: Notice to California Applicants: Under section 1786.22 of California Civil Code, you have the right to request from NationSearch, upon proper identification, the nature and substance of all information in files pertaining to you, including the sources of information, and recipients of any reports on you, which NationSearch has previously furnished within the two-year period preceding your request. You may view the file maintained on you by contacting NationSearch during normal business hours. You may also obtain a copy of this report(s) upon submitting proper identification. Upon making a written request, you may receive a summary of your report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly.

Notice to Maine Applicants: Under Chapter 210 Section 1314 of Maine revised Statutes, you have the right, upon request, to be informed within 5 business days of such a request to whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency, NationSearch and request a copy of the report(s) compiled.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

Last Name: <i>Ear</i>	First: <i>Allison</i>	SS# <i>522-93-3958</i>
Other Names used:		Date of Birth: For employment Purposes Only <i>06/04/1994</i>
Motor Vehicle Number and State of Issue: (Driver's License #, NOT License Plate #) <i>09-203-0874</i>		
Address: <i>2012 E. 134th way Thornton, CO 80241</i>		

Signature: *Allison Ear*

Date: *07/27/14*

Please initial this box in affirmation that you have been advised of your rights as it pertains to this consumer investigative report, and are aware of the agency conducting the investigation:

AE

Allison Ear Allison Ear Allison Ear

2012 East 134th Way Thornton, CO 80241 • Phone: 720-226-5390 • E-Mail: allisonear@hotmail.com

Objective

Seeking a full-time employment opportunity. Willing to work 40+ hours per week. I am able to be on my feet and active all day. Open for various areas of work and will be willing to learn, train, and become certified if necessary.

Experience

August 2013- Present

Customer service, building displays, stocking, price changes, area zones, unloading trucks, working with pallet jacks

October 2012- August 2013

Specimen management- handling, organizing, inventory, storage

Basic admin work- labeling, filing, sorting, documenting, data entry, work with MS word, excel, powerpoint, collective access

July 2009- Present

Education

August 2013-Present

August 2012-May 2013

August 2008-May 2012

- *National Honor Society*
- *Bollman Technical Education Center- Culinary Arts & Business Management course (Serve Safe Certification, First Aid Training, and CPR AED)*

Skills

Colorado
Driver License

09-203-0874 Expires 06-24-2015
Issued 07-22-2010

ALLISON NICOLE EAR
2012 E. 134TH WAY
THORNTON, CO 80241

UNDER 21
DOB 06-04-1994



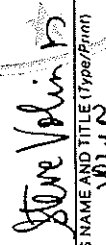
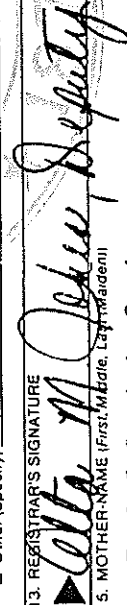

Class: R
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Res: V 505
HT: 120
WT:
Sex: F
Eyes: BRO
Notes:

AGE

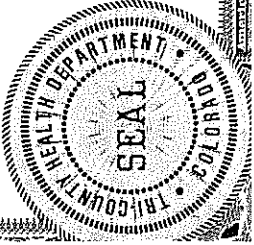
CERTIFICATION OF VITAL RECORD

STATE OF COLORADO

STATE OF COLORADO
CERTIFICATE OF LIVE BIRTH 105

STATE FILE NUMBER		2. DATE AND HOUR OF BIRTH (Month, Day, Year, ZIP)	
Allison		June 4, 1994 0207	
3. SEX		5. COUNTY OF BIRTH	
Female		Adams	
6. PLACE OF BIRTH: <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center			
<input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Residence			
7. FACILITY NAME (if not institution, give street and number)			
North Suburban Medical Center			
10. ATTENDANT'S NAME AND TITLE (if other than Certified) (Type/Print)			
Name			
<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> C.N.M. <input type="checkbox"/> REGISTERED MIDWIFE			
<input type="checkbox"/> Other (Specify)			
12. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code)			
9141 Grant Street Thornton, CO 80229			
8. I certify that this child was born alive at the place and time and on the date stated.		9. DATE SIGNED (Month, Day, Year)	
Signature 		6/4/94	
11. CERTIFIER'S NAME AND TITLE (Type/Print)			
Name			
<input checked="" type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Hospital Admin. <input type="checkbox"/> C.N.M. <input type="checkbox"/> REGISTERED MIDWIFE			
<input type="checkbox"/> Other (Specify)			
13. REGISTRAR'S SIGNATURE			
			
15. MOTHER-NAME (First, Middle, Last, Maiden)			
Isabel Leticia Ontiveros			
18a. RESIDENCE-STATE		18b. COUNTY	
Colorado		Adams	
18e. STREET AND NUMBER			
8079 Wolff Street #G			
20. FATHER-NAME (First, Middle, Last)			
Song Ear			
23. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.			
Signature of Parent or Other Informant 			
14. DATE FILED BY REGISTRAR (Month, Day, Year)		17. BIRTHPLACE (State or Foreign Country)	
JUN 08 1994		Mexico	
18c. CITY, TOWN OR LOCATION		18d. ZIP:	
Westminster		80030	
19. MOTHER'S MAILING ADDRESS (if different than residence)			
21. DATE OF BIRTH (Month, Day, Year)			
22. BIRTHPLACE (State or Foreign Country)			
24. RELATION TO CHILD			
mother			

01-038896



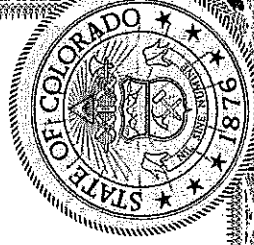
DATE ISSUED
AUG 25 1994



H. H. ROHRER, M.D.
LOCAL REGISTRAR

Do not accept unless prepared on security paper with engraved border displaying the Colorado state seal and signature of the Registrar. PENALTY BY LAW, Section 25-2-118, Colorado Revised Statutes, 1982, if any person alters, uses, attempts to use or furnishes to another for deceptive use any vital statistics record. NOT VALID IF PHOTOCOPIED.

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD WHICH IS IN MY CUSTODY.



VR 100C 8/88