



7301 Ohms Lane / Suite 405  
Edina, MN 55439  
T:952.835.1288 / F:952.835.4881

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

Last Name Swenson First Name Heather Middle Initial M  
Street Address 444 Pawnee Rd.  
City/State/Zip McPherson, KS 67460  
Home Phone N/A Cell / Message Phone (620) 455-1429  
Company/Employer Corporate Management Group

**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.

Heather M. Swenson Name (Print or type) Heather M. Swenson Applicant's Signature 11/10/14 Date

A copy or facsimile will be considered the same as an original signature.

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	5 Day Letter (If applicable) _____	ESC Application _____

## Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen. If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck. The time that the money goes into your account on pay day varies by bank. Please allow until at least 10 am on your payday for the deposit to show.

**Please print**

Check one of the following	Effective Date
<input checked="" type="checkbox"/> Start	<input checked="" type="checkbox"/> As Soon As Possible
<input type="checkbox"/> Stop	<input type="checkbox"/> Future Paydate
<input type="checkbox"/> Change	_____ / _____ / _____

Social Security Number  
**480-08-5187**

Name (Last, First Middle Initial) <b>Swenson, Heather M.</b>				
Home Address Street: <b>444 Pawnee Rd</b>		City <b>McPherson</b>	State <b>KS</b>	Zipcode <b>67460</b>
Date (Mo/Day/Yr) <b>11/10/14</b>	Employee Signature <i>Heather M. Swenson</i>		Daytime Phone Number <b>(660) 755-1429</b>	

**SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION**

Financial Institution Name (Bank, Savings Institution, Credit Union, etc.)  
**Farmers State Bank, Lindsborg, KS**

Type of Account

Checking     Savings     Money Market Checking     Money Market Investment Requires Submission of ACH form from your broker

I authorize Employer Solutions Staffing Group to direct deposit funds to my account in the financial institution listed above. If funds to which I am not entitled are deposited in my account, I authorize Employer Solutions Staffing Group to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by Employer Solutions Staffing Group at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to you will be returned to Employer Solutions Staffing Group for distribution. This will delay payment of funds to you.

<p><b>HEATHER SWENSON</b> 444 PAWNEE RD. MCPHERSON, KS 67460</p>	<p>88-838/1011</p>	<p><b>1227</b></p>
DATE _____		
VOID		
PAY TO THE ORDER OF	VOID	\$ VOID
MEMO		VOID
<b>FARMERS STATE BANK</b> LINDSBORG, KANSAS		
SECURITY FEATURES INCLUDED Data Protection		
⑆ 101108380⑆ 92 885 20⑆ 1227		



# Employment Eligibility Verification

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

USCIS  
Form I-9

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) Swenson		First Name (Given Name) Heather		Middle Initial M	Other Names Used (if any)	
Address (Street Number and Name) 444 Pawnee Rd.			Apt. Number	City or Town McPherson		State KS
Zip Code 67460		Date of Birth (mm/dd/yyyy) 06/20/1974	U.S. Social Security Number 480-08-5187	E-mail Address knhdesigns@gmail.com		Telephone Number (620)755-1429

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: \_\_\_\_\_

3-D Barcode  
Do Not Write in This Space

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: <i>Heather M. Swenson</i>	Date (mm/dd/yyyy): <i>11/10/2014</i>
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**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):		
Last Name (Family Name)		First Name (Given Name)			
Address (Street Number and Name)		City or Town		State	Zip Code



Employer Completes Next Page



## 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 Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: <u>Driver License</u>		Document Title: <u>SS Card</u>
Issuing Authority:		Issuing Authority: <u>KS</u>		Issuing Authority: <u>SS Admin</u>
Document Number:		Document Number: <u>601-04-8975</u>		Document Number: <u>480-08-5197</u>
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy): <u>6.20.17</u>		Expiration Date (if any)(mm/dd/yyyy):
Document Title:				<div style="border: 1px solid black; padding: 5px;"> <p>3-D Barcode Do Not Write in This Space</p> </div>
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

## Certification

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

The employee's first day of employment (mm/dd/yyyy): 11.17.14 (See instructions for exemptions.)

Signature of Employer or Authorized Representative <u>Tina Pool</u>		Date (mm/dd/yyyy) <u>11.18.14</u>	Title of Employer or Authorized Representative <u>Acct Mgr.</u>	
Last Name (Family Name) <u>Pool</u>		First Name (Given Name) <u>Tina</u>	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	Zip Code

## 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):
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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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**KANSAS DL**



COMM CLS N COMM CLS C  
 ISS 06-21-2011 EXP 06-20-2017  
 SEX F HT 5-06 EYES BLU WT 130  
 DOB 06-20-1974 ENDRS  
 ORGAN DONOR ♥

SWENSON, HEATHER MARIE  
 444 PAWNEE ROAD  
 MCPHERSON, KS 67460

HEATHER SWENSON  
 LICENSE NUMBER K01-04-8975  
 REST CORRECTIVE LENSES

**SOCIAL SECURITY**

SOCIAL SECURITY  
 630-08-5197  
 THIS NUMBER HAS BEEN ESTABLISHED FOR  
 HEATHER MARIE SWENSON  
 HEATHER SWENSON  
 SIGNATURE

**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 480-08-5187  
Date of Birth 06/20/1974 Sex  M  F  
Name Heather M. Swenson  
Street Address 444 Pawnee Rd.  
City McPherson State KS Zip 67460  
Home Phone 620-755-1429

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
- NO \$0.90 Employee + One
- NO \$1.80 Employee + Family

**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 Kirk T. Swenson  
Social Security Number 511-80-6131  
Date of Birth 10/12/1966 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**

Kirk T. Swenson

**RELATIONSHIP**

Spouse

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 Heather M. Swenson

Date 11/10/2014

**Form A (revised 07/09) WORK OPPORTUNITY TAX CREDIT**

**PLEASE CHECK "YES" OR "NO" AND ANSWER ALL QUESTIONS**

Name Heather M. Swenson  
Address 444 Pawnee Rd.  
City McPherson State KS Zip 67460 Social Security # 480-08-5187  
Date of Birth 06/20/1974 Age 40

**Please CHECK ONE ANSWER for each of the following questions, and complete question #5:**

- 1. Have you or any family member living with you received Temporary Assistance to Needy Families (TANF) or Aid to Families with Dependent Children (AFDC) during the past 24 months? Yes  No
- 2. Have you or any family member living with you received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) at any time during the past fifteen (15) months? Yes  No
- 3. Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days? Yes  No
- 4. Are you part of the Ticket to Work program? Yes  No

**5. Name of person who received benefits \_\_\_\_\_  
Relationship \_\_\_\_\_ City & State where benefits received \_\_\_\_\_**

6. Are you a veteran? Yes  No  and Disabled due to service? Yes  No   
Service Dates: From: \_\_\_\_\_ To: \_\_\_\_\_ Branch: \_\_\_\_\_

7. Have you been unemployed at any time during the last 12 months? Yes  No   
If yes, dates of unemployment: From: 03/17/2014 To: Present  
Did you receive unemployment compensation at any point during your unemployment?  
If yes, dates received compensation: From: \_\_\_\_\_ To: \_\_\_\_\_ Yes  No

8. Have you been convicted of a felony or released from prison in the last 12 months? Yes  No   
Date of Conviction: \_\_\_\_\_ Date of Release: \_\_\_\_\_  
Parole Officer's Name: \_\_\_\_\_ Parole Officer's Phone # \_\_\_\_\_

9. Have you received rehabilitation services from a State approved or Department of Veterans Affairs approved Vocational rehabilitation agency? Yes  No   
Name of Agency \_\_\_\_\_ Phone # \_\_\_\_\_  
Address of Agency \_\_\_\_\_ Counselor's Name \_\_\_\_\_

10. Have you attended High School, College or Technical School for more than an average of 10 hours per week at any time during the last 6 months? Yes  No

11. Did you receive a high school diploma or GED? If yes, date received: \_\_\_\_\_ Yes  No   
Have you been employed or been admitted to technical school or college since then? Yes  No

12. How much in gross wages have you earned TOTAL in the past six months? \$ 0

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, or the Department of Labor.  
→ NEW HIRE SIGNATURE Heather M. Swenson DATE 11/10/14

Questions below to be completed by manager  
Starting Wage \_\_\_\_\_ Position \_\_\_\_\_  
Has employee worked for this company before? \_\_\_\_\_ If yes, date and location \_\_\_\_\_

Form **8850**  
(Rev. August 2009)  
Department of the Treasury  
Internal Revenue Service

## 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 Heather M. Swenson Social security number ▶ 480-08-5187

Street address where you live 444 Pawnee Rd. ~~Kan~~

City or town, state, and ZIP code McPherson, KS 67460

County McPherson Telephone number (620) 755-1489

If you are under age 40, enter your date of birth (month, day, year) \_\_\_\_\_

- 1  Check here if you are completing this form **before** August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.
- 2  Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 3  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 discharged or released from active duty in the U.S. Armed Forces during the past 5 years **and**, for at least 4 weeks during the past year, I received unemployment compensation.
  - I am at least age 16 but **not** age 25 or older, **and**:
    - a During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, **and**
    - b During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, **and**
    - c I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate **or** I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.
- 4  Check here if you are a veteran entitled to compensation for a service-connected disability **and**, during the past year, you were:
- Discharged or released from active duty in the U.S. Armed Forces, or
  - Unemployed for a period or periods totaling at least 6 months.
- 5  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 ▶ Heather M. Swenson

Date 11/10/14

← Cut here and give the lower portion to your employer. Keep the top portion for your records.

# K-4 Kansas Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemptions from withholding is (Rev. 9/12) subject to review by KDOR. Your employer may be required to send a copy of this form to KDOR.

1 Print your first name and middle initial <i>Heather M.</i>	Last Name <i>Swenson</i>	2 Social Security Number <i>480-08-5187</i>
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Mailing Address <i>444 Pawnee Rd.</i>	3 Allowance Rate Mark the allowance rate selected in line A above.  <input checked="" type="radio"/> Single <input type="radio"/> Joint
City or Town, State, and ZIP Code <i>McPherson, KS 67460</i>	

4 Total number of allowances you are claiming (from line F above) .....	4	<i>4</i>
5 Enter any additional amount you want withheld from each paycheck (this is optional) .....	5	\$ <i>0</i>
6 I claim exemption from withholding. You must meet the conditions explained in the "Exemption from withholding" instructions above. If you meet those conditions, write "Exempt" on this line. .... <b>Note: KDOR will receive your federal W-2 forms for all years claimed Exempt.</b>	6	

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.

SIGN  
HERE ← *Heather M. Swenson*

DATE *11/10/14*

7 Employer's name and address	8 EIN (Employer Identification Number)
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# HIRE Act FICA Payroll Holiday and Employee Retention Tax Credit Employee Affidavit

Employer Name: Corporate Management Group FEIN: \_\_\_\_\_

Hire Location: Hospira, McPherson, KS

Employee Name: Heather M. Swenson

Social Security Number: 480-68-5187 1<sup>st</sup> Day of Work: \_\_\_\_\_

**EMPLOYEE: Please check **One** statement that applies to you and sign and date where indicated below.**

- I was unemployed during the entire 60 day-period prior to my first day of employment at this company.
  - I worked less than a total of 40 hours during the 60-day period prior to my first day of employment at this company.
- OR
- I worked MORE than a total of 40 hours during the 60-day period prior to my first day of employment at this company.

**Under penalties of perjury, I hereby declare that the information above is true and correct to the best of my knowledge. By signing this form, I hereby authorize the release to my new employer or its agents information held by any parties needed to determine my eligibility for federal and/or state incentive programs.**

Employee Signature: Heather M. Swenson Today's Date: 11/10/14

For employer's use only:

- Employee is being hired for a new position within the company.
- Employee is replacing an employee who either quit or was terminated with just cause.
- Employee is replacing an employee who was laid off.

Hiring Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**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: Heath M. Jackson  
Date/Fecha: 11/10/14

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

Name: *Heather M. Swenson*  
Address: *444 Pawnee Rd. McPherson, KS 67460*  
Home Phone: *(620) 755-1429 (cellular)*

Person(s) to contact in case of an emergency on the job (in order of preference):

1. **Name:** *Kirk Swenson*  
**Phone (work):** *(785) 819-1828*  
**Phone (home):** *(785) 819-1828*
2. **Name:** *Malinda Hansen*  
**Phone (work):** *(319) 626-2391*  
**Phone (home):** *(319) 530-8235*

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

*No Known Allergies or Medical Conditions*

Hospira's Non-Employee Questionnaire - NEO

The NEQ is required for all contractors or vendors who will need physical access to a Hospira facility or access to any network or software program administered by Hospira. In order to gain access, a UID number (Unique Identifier) will be issued. The UID is only issued once the NEQ is completed and a criminal background check is completed. Hospira does not conduct consumer or credit checks on contractors or vendors. However, because Hospira does use a 3<sup>rd</sup>-party background screening company to perform our background checks, we are governed by the Fair Credit Reporting Act, therefore, the applicable FCRA forms are included in this packet.

If you are going to be physically working in a Hospira facility, you are also required to complete a Badge Access Form. This will expedite the process of you obtaining access to Hospira facilities.

When completing the NEQ, please keep these in mind:

- 1. ~~Clearly print your full family name.~~
- 2. ~~Make sure that all questions are answered completely and honestly.~~
- 3. Only the LAST FOUR (4) digits of your Social Security Number need to be placed on the NEQ. This will assist the background screening company in identifying you from someone else
- 4. ~~On Question #8, understand that the background screening company may call you and ask questions about ANY prior conviction that you did not put on your NEQ. This may delay the process. Even a DUI must be reported. A conviction of a crime will not necessarily disqualify you from placement. However, failure to report a prior conviction may disqualify you from consideration.~~
- 5. ~~Indicate whether you have ever worked at Hospira, Abbott Laboratories or TAP. If so, please provide dates. If you worked previously as a contractor at Hospira, Abbott or TAP, provide dates and the name of the contract company.~~
- 6. ~~Once you have completed the NEQ, either return it to where you received the document or fax it to Hospira's Global Security department at 224-212-3384. Questions should be directed to the hiring manager, Hospira staffing department where you will be placed, or to Global Security.~~

**HOSPIRA, INC. NON-EMPLOYEE QUESTIONNAIRE**

1. ~~Name~~ Swenson Heather Marie  
(last) (first) (middle)

2. ~~Last Four (4) digits of your Social Security No. XXX-XX-~~ 5187

3. ~~Other Names (Maiden/Alias)~~ Heather Ulrich 4. Date of Birth 06 / 20 / 74

5. ~~Are you able to lawfully work in the United States?~~  Yes  No  
Describe your visa status, if applicable \_\_\_\_\_

6. ~~List all home addresses for the past 5 years, starting with the most recent (use separate sheet if necessary):~~

10/2000 - present 444 Pawnee Rd. McPherson KS McPherson  
(mo/yr to mo/yr) (number & street) (City) (State) (County)

(mo/yr to mo/yr) (number & street) (City) (State) (County)

(mo/yr to mo/yr) (number & street) (City) (State) (County)

Are you a high school graduate or possess a GED?  Yes No School Attended Highland High School, Riverside, IA

Have you EVER been convicted of a felony, or any misdemeanor, or are you presently formally charged with committing a criminal offense? (Do not include **minor** traffic violations, juvenile offenses, or military convictions except by general court martial. Driving under the influence is not considered a minor traffic offense.). Conviction of a crime will not necessarily disqualify you from placement. Yes  No

If yes, give details including offense, date, location, conviction detail and sentence. Use separate sheet if necessary.

Please note that you are not required to disclose any information as it relates to any juvenile arrest(s), or any information contained in sealed or expunged records of conviction.

In the past three (3) years have you ever knowingly and unlawfully trafficked, used, or possessed any drugs other than those prescribed to you by a physician? Yes  No

If yes, provide details: \_\_\_\_\_

Have you ever been employed by Hospira, TAP or Abbott Laboratories either as a contractor or an employee? Yes  No

If yes, provide dates & contract company: \_\_\_\_\_

Current employer: N/A

Dates employed with current employer: \_\_\_\_\_

**GOVERNMENT REGULATORY QUESTIONS**

The following questions are being asked for purposes of compliance with the Federal Procurement Integrity Act and the Ethics in Government Act.

Have you ever worked for any federal government agency (military or civilian), Congress, or the District of Columbia, including work as an advisor or special government employee? If no, proceed to the next set of questions. Yes  No

Are you currently participating, or within the past year have you served, in any capacity on a federal contract over \$10 million that was awarded to Hospira? Yes  No

Are you currently participating in, or within the past year have you personally made, any decision to award a contract, subcontract, contract modification, or delivery order over \$10 million to Hospira? Yes  No

Are there any restrictions resulting from your current or past government service that might limit the duties you could perform for Hospira? Yes  No

If yes, give details: \_\_\_\_\_

**4- The following questions are being asked for purposes of compliance with the Generic Enforcement Act of 1992 enforced by the United States Food and Drug Administration:**

Have you ever been debarred by the FDA? Yes  No If yes, give details.

To the best of your knowledge, is the FDA going to commence debarment proceedings against you? Yes  No

To the best of your knowledge, within the last 5 years, have you, or anyone else with or for whom you have worked participated in actions that were the basis for a conviction of another person, for conduct relating to the development, approval or regulation of any drug product under the Federal Food, Drug, and Cosmetic Act? Yes  No

Do you promise to advise Hospira immediately if the FDA commences debarment proceedings against you?  Yes  No

**5- The following questions are being asked to ensure that Hospira fulfills its responsibilities as a contractor to the Federal Government:**

Are you presently listed on the List of Parties Excluded from Federal Procurement and Non-Procurement Programs maintained by the General Services Administration? (This would be the case if, among other things, you were presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal agency.) Yes  No

Do you promise to advise Hospira immediately if you become listed on the List of Parties Excluded from Federal Procurement and Non-Procurement Programs?  Yes  No

**6- The following questions are being asked to ensure that Hospira fulfills its responsibilities as a manufacturer of products that may be reimbursed by Medicare, Medicaid, or other Federal health care programs:**

Are you presently excluded from participation in a Federal health care programs? Yes  No

Have you been convicted of any offense that requires your exclusion from Federal health care programs, but not yet excluded? Yes  No

Do you promise to advise Hospira immediately if you are excluded from Federal health care programs, or convicted of a criminal offense that requires your exclusion?  Yes  No

## WORKER RESPONSIBILITY AND CONFIDENTIALITY AGREEMENT

During times that my employer assigns me to work at Hospira, Inc. ("Hospira"), I may have access to confidential and/or proprietary information of Hospira including but not limited to sales, marketing, financial, manufacturing, personnel, research, scientific, technical, production, and computer systems information or documentation ("Confidential Information").

I agree to hold in confidence all Confidential Information which may come to my attention and not to disclose such information to any third party nor to use such information for my own or anyone else's benefit at any time. I further agree to notify Hospira Inc. immediately of any inadvertent access to any such information by third parties while it is in my possession. Such agreement of confidentiality shall not apply to:

- Information developed by me outside the terms of this Agreement and independent of any knowledge gained from Hospira;
- Information in the public domain or which comes into the public domain through no fault of mine; and (c) Information disclosed to me by third parties not under any duty to Hospira not to disclose.

Any and all inventions, discoveries and innovations (whether patentable, copyrightable or not), trademarks, trade dress, trade designs, information, suggestions, ideas, communications, designs, documents, materials and reports conceived, reduced to practice or otherwise created as a result of or in connection with services I perform while assigned to work at Hospira shall be promptly disclosed to Hospira and shall be the sole property of Hospira. At Hospira's request and expense, I shall execute such documents and take such other steps as Hospira deems necessary or appropriate to obtain, vest, confirm or record ownership of all right, title and interest in the foregoing in Hospira's name, including without limitation patent, trademark and copyright ownership.

**I acknowledge that I shall not be an employee of Hospira for any purpose. This Agreement shall not entitle me to participate in any benefit plan or program for employees of Hospira, and I hereby waive any and all rights I may have to participate in any such plans or programs. I am not entitled to worker's compensation coverage by Hospira, and I hereby waive any and all rights I may have to be covered under Hospira's worker's compensation policies.**

I shall not remove any items from Hospira's facilities in order to provide Services for Hospira or for any other reason without the prior written consent of Hospira Management and completion of a Receipt.

If the foregoing terms and conditions are acceptable, please sign and date both originals of this Agreement and return one (1) fully-executed original to Hospira.

I have read and understand the information provided above and authorize Hospira, Inc. or an authorized vendor to act accordingly to these statements.

Signature Weather M. Swenson

Date 11/05/14

### **CONSUMER REPORT DISCLOSURE & AUTHORIZATION**

Pursuant to provisions of the Fair Credit Reporting Act, it is a requirement that any third-party background screening company that Hospira uses to conduct a background check, must obtain written permission to report their findings back to Hospira. For all Non-Employees, Hospira requires a minimum of a criminal background check be completed before any access to facilities or networks are made available to the applicant. In addition, Hospira, Inc. requires that a motor vehicle check be completed for those individuals whose duties and responsibilities require him/her to operate a motorized vehicle at work.

I hereby acknowledge notification that an inquiry may be requested to procure information relating to criminal history and also, if applicable, a motor vehicle history. I understand that I may make a written request for a copy of any materials or records obtained through the background checks as explained above; however, all records are the property of Hospira.

In connection with any inquiry that may be requested, I hereby authorize all public and private individuals, courts and law enforcement agencies, corporations, organizations, firms, institutions and agencies who possess information about me to release to Hospira, Inc. or any designated representative thereof, without liability, any and all information

concerning the aforementioned areas of inquiry, and to allow copies to be made of any requested written data. I understand that any information furnished in this questionnaire or obtained as a result of any inquiry will not necessarily preclude my association with Hospira, Inc. but will be used as part of an overall evaluation of my qualifications.

As a condition of my association with Hospira, Inc., I will never knowingly and unlawfully use or possess any drugs or illegal substances not authorized or prescribed by a physician. I am aware that a violation of this condition will result in the immediate termination of my association with Hospira, Inc. I also understand that my association with Hospira, Inc. will be subject to immediate termination if any of the information I have given verbally or in writing on any company document is false, or if I have failed to give material information requested.

**I have read and understand the information provided above and authorize Hospira, Inc. or an authorized vendor to act accordingly to these statements.**

Signature Heather M. Swenson Date 11/05/14

Printed Name: Heather M. Swenson

PLEASE RETURN A COMPLETED FORM TO HOSPIRA'S GLOBAL SECURITY DEPARTMENT AT 224-212-3384 OR TO THE LOCAL HOSPIRA PLANT STAFFING DEPARTMENT WHERE YOU WILL BE RESIDING

### A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to [www.ftc.gov/credit](http://www.ftc.gov/credit) or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

**You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.





## Employee Acknowledgement Form (Temps)

I hereby acknowledge receipt of Storeroom Solutions Inc. "**Employee Safety Handbook**" which outlines important safety requirements and information for working as safety as possible. I agree to follow the safety and health rules as outlined in this handbook. I further understand that complete safety and health program requirements are published in the "**Safety Manual**" that can be obtained through my Site Manager or Project Leader.

*Heather M. Swenson*

Employee Signature

*11/10/14*

Date

\_\_\_\_\_  
Employer's Representative

\_\_\_\_\_  
Date

**Important:** This receipt must be read, understood and signed by all Storeroom Solutions Inc. permanent and temporary employees. Temporary employees sign this hard-copy form. Permanent employees must document their training in the SSI Learning Center by taking the associated quiz.

### **Documentation Instructions:**

**Permanent Employees:** The SSI Site Manager, or senior SSI employee, will ensure all personnel have read and understand the contents of this document. Please contact the Senior Director of Safety and Quality [safety@storeroomsolutions.com](mailto:safety@storeroomsolutions.com) if you have any questions. The employee must take the Employee Safety Handbook Quiz contained in the SSI Learning Center.

**Temporary/Project Employees:** The project leader or hiring manager will ensure all personnel have read and understand the contents of this document. Please contact the Senior Director of Safety and Quality [safety@storeroomsolutions.com](mailto:safety@storeroomsolutions.com) if you have any questions. The employee and leader or manager will sign this form file it on site. This form is a special interest item during implementation audits.

**Employees:** *Please retain the handbook for future reference.*