Employer Solutions Staffing Group LLC

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

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Winters **First Name** Brenda **Middle Initial** K

Street Address 97 Kiowa Rd

City/State/Zip Windom KS 67491

Home Phone 620-778-3933 **Cell / Message Phone** 620-778-3933

Company/Employer

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.

Brenda Winters — Name (Print or type)

Brenda Winters — Applicant's Signature

11-13-14 — 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**

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)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*
Winters	Brenda	K	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code
27 Kiowa Rd		Windom	KS	67491

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
11-21-56	519-64-1814	wntrs-brnd@yahoo.com	620-278-3933

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)*

3-D Barcode
Do Not Write in This Space

Signature of Employee: Brenda Winters	Date *(mm/dd/yyyy)*: 11-13-2014

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

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 and Employment Authorization	**Identity**	**Employment Authorization**
Document Title:	Document Title: Driver License	Document Title: SS Card
Issuing Authority:	Issuing Authority: KS	Issuing Authority: dept of health
Document Number:	Document Number: K03-10-1660	Document Number: 514-64-1814
Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*: 11-21-15	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)*: 11-15-2014 **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
[signature]	11.18.14	Acct Mgr.

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Kool	Tina	

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)*:

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:

KANSAS DL

03-02-2010

5-01

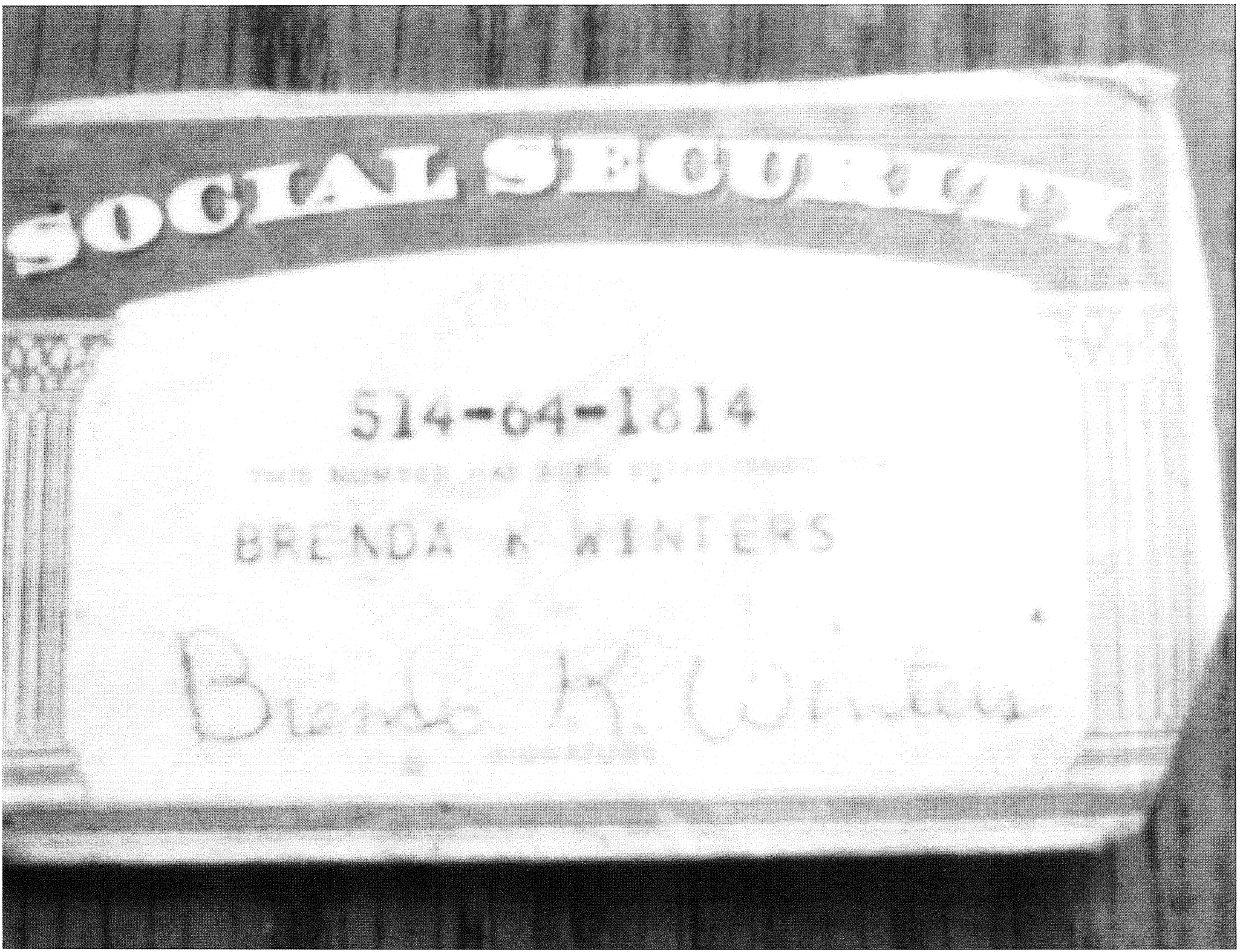
DOB 11-21-1956

ORGAN DONOR

WINTERS BRENDA K
201 PECAN

MOUND VALLEY, KS 67354

LICENSE NUMBER K03-10-1660


SOCIAL SECURITY
514-04-1814
BRENDA B WINTERS

employer solutions staffing group LLC

Leveraging Resources in a Changing Market

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): Brenda Winters

Signature/Firma: Brenda Winters

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.

Brenda Winters 11-13-14

Employee Signature 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 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 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.***

VSI-IND 219301-EMP | OFFICE USE ONLY | ReHire Date ___/___/_____

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 514-64-1814

Date of Birth 11/21/1956 Sex M [F]

Name Brenda Winters

Street Address 27 Kiowa Rd

City Windom State KS Zip 67491

Home Phone 620-778-3933

Do you or any dependents have Medicare?
☐ Yes [X] 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

[X] $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

[X] **YES** $0.60 Employee Only
$0.90 Employee + One
☐ **NO** $1.80 Employee + Family

SHORT-TERM DISABILITY

☐ **YES**
☐ **NO** $4.20 Employee Only

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
Hubert Davis

RELATIONSHIP
Partner

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** Date ___/___/_____

HIRE Act FICA Payroll Holiday and Employee Retention Tax Credit

Employee Affidavit

Employer Name: _____ FEIN: _____

Hire Location: _____

Employee Name: Brenda Winters

Social Security Number: 514-64-1814 **1st Day of Work:** 11-15-14

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: Brenda Winters Today's Date: 11-13-14

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: _____

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

Name: Brenda Winters

Address: 27 Howard Winfield KS 67491

Home Phone: 620-778-3933

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

1. **Name:** Lee Davis

   Phone (work): _____

   Phone (home): 620-313-0889

2. **Name:** _____

   Phone (work): _____

   Phone (home): _____

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

CMG
CORPORATE MANAGEMENT GROUP
"your workforce management & staffing experts"

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: Brenda Winters

Date: 11-13-2014

K-4 KANSAS

(Rev. 10/13)

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Use the following instructions to accurately withheld because you had no tax liability; a K-4 form from you, they must withhold complete your K-4 form, then detach the and **2)** this year you will receive a full refund Kansas income tax from your wages lower portion and give it to your employer. of all STATE income tax withheld because without exemption at the "Single" For assistance, call KDOR (Kansas you will have no tax liability. allowance rate.

Department of Revenue) at 785-368-8222. **Basic Instructions:** If you are not exempt, **Head of household:** Generally, you may **Purpose of the K-4 form:** A completed complete the **Personal Allowance** claim head of household filing status on withholding allowance certificate will let **Worksheet** that follows. The total on line F your tax return only if you are **unmarried** your employer know how much Kansas should not exceed the total exemptions you **and pay more than 50% of the cost of** income tax should be withheld from your claim under "Exemptions and Dependents" **keeping up a home for yourself and for** pay on income you earn from Kansas on your Kansas income tax return. **your dependent(s).**

sources. Because your tax situation may NOTE: Your status of "Single" or "Joint" may **Nonwage income:** If you have a large change, you may want to refigure your differ from your status claimed on your amount of nonwage Kansas source withholding each year. federal Form W-4). income, such as interest or dividends,

Exemption from Kansas withholding: To Using the information from your **Personal** consider making estimated tax payments qualify for exempt status you must verify **Allowance Worksheet**, complete the **K-4** on Form K-40ES. Without these payments, with KDOR that: **1)** last year you had the form below, sign it and provide it to your you may owe additional Kansas tax when right to a refund of all STATE income tax employer. If your employer does not receive you file your state income tax return.

Personal Allowance Worksheet (Keep for your records)

A Allowance Rate: If you are a single filer mark "Single" A (9) Single

If you are married and your spouse has income mark "Single" (9) Joint

If you are married and your spouse does not work mark "Joint"

If in a same-sex relationship and considered married by the laws of another state mark "Single"

B Enter "0" or "1" if you are married or single and no one else can claim you as a dependent (entering "0" may help you avoid having too little tax withheld) ..... B 1

C Enter "0" or "1" if you are married and only have one job, and your spouse does not work (entering "0" may help you avoid having too little tax withheld) ..... C 0

D Enter "2" if you will file head of household on your tax return (see conditions under Head of household above) ..... D 0

E Enter the number of dependents you will claim on your tax return. Do not claim yourself or your spouse or dependents that your spouse has already claimed on their form K-4 ..... E 0 **F Add lines B through E** and enter the total here ..... F 0

⇦ 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 subject to review by KDOR. Your employer may be required to send a copy of this form to KDOR.

(Rev. 9/12)

1 Print your first name and middle initial	Last Name	2 Social Security Number
Brenda . K	Winters	514-64-1814

Mailing Address: 27 Kiowa Rd

City or Town, State, and ZIP Code: Windom KS 67491

3 Allowance Rate
Mark the allowance rate selected in line A above.

(9) Single (9) Joint

4	Total number of allowances you are claiming (from line F above)	4 1
5	Enter any additional amount you want withheld from each paycheck (this is optional)	5 $
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. **Note: KDOR will receive your federal W-2 forms for all years claimed Exempt.**	6 1

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 ⇦ Brenda Winters DATE 11-13-2014

7 Employer's name and address	8 EIN (Employer Identification Number)

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

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

▶ See separate instructions.

OMB No. 1545-1500

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

Your name Brenda Winters Social security number ▶ 514-64-1814

Street address where you live 27 Kiowa Rd

City or town, state, and ZIP code Windom KS 67491

County USA Telephone number (620) 278-3933

If you are under age 40, enter your date of birth (month, day, year) 11-21-1956

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 ▶ Brenda Winters **Date** 11/13/2014

For Employer's Use Only

Employer's name Employer Solutions Staffing Group Telephone no. (952) 835 - 1288 EIN ▶

Street address 7301 Ohms Lane, Suite 405

City or town, state, and ZIP code Edina, MN 55439

Person to contact, if different from above Associated Consultants, Inc. Telephone no. (800) 925 - 0557

Street address 3730 Washington Boulevard

City or town, state, and ZIP code Indianapolis, IN 46205

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 information / / Was offered job / / Was hired / / Started job / /

Complete Only If Box 1 on Page 1 is Checked

State and county or parish of job

☐ Check if the individual was not your employee on August 28, 2005, and this is the first time the employee has been hired by you since August 28, 2005.

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 . . . 3 hrs., 16 min.
Learning about the law or the form . . . . . 46 min.
Preparing and sending this form to the SWA . . . . . 42 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:T:SP, 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.

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

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

Name Brenda Winters
Address 27 Crowe Rd
City Windom State KS Zip 67491 Social Security # 514-64-1814
Date of Birth 11-21-1956 Age 57

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: 8-1975 To: 8-1979 Branch: Army Reserve

7. Have you been unemployed at any time during the last 12 months? **Yes** ☒ **No** ☐
If yes, dates of unemployment: From: July 2014 To: 11-13-14
Did you receive unemployment compensation at any point during your unemployment?
If yes, dates received compensation: From: July 2014 To: 11-13-14 **Yes** ☒ **No** ☐

8. Have you been convicted of a felony or released from prison in the last 12 months?
Date of Conviction: _____ Date of Release: _____ **Yes** ☐ **No** ☒
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: 1974 **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? $ _____

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 Brenda Winters DATE 11-13-14

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

Hospira's Non-Employee Questionnaire - NEQ

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 3rd-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 Winters (last) Brenda (first) Kay (middle)

2. Last Four (4) digits of your Social Security No. XXX-XX-1814

3. Other Names (Maiden/Alias) Caldwell 4. Date of Birth 11/21/56

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):

8-79 to 2012 (mo/yr to mo/yr) 110 west 2nd (number & street) Mound Valley (City) KS (State) Labette (County) USA

Revised 05/06

(mo/yr to mo/yr)	(number & street)	(City)	(State)	(County)
1-2012 to 8-2014	1943 Knox Rd Apt 1	Meridian	MS	Lauderdale
8-2014 to 11-2014	97 Kiowa Rd	Windom	KS	McPherson

7. Are you a high school graduate or possess a GED? (Yes) No School Attended Parsons High

8. 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.

9. 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: _____

10. 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: _____

11. Current employer: None

12. Dates employed with current employer: _____

GOVERNMENT REGULATORY QUESTIONS

13. **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: _____

14. **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

15. **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 advice Hospira immediately if you become listed on the List of Parties Excluded from Federal Procurement and Non-Procurement Programs? (Yes) No

16. **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 heath care programs, but not yet excluded? Yes (No)

Do you promise to advise Hospira immediately if you are excluded from Federal heath 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:

(a) Information developed by me outside the terms of this Agreement and independent of any knowledge gained from Hospira;

(b) 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 Brenda K. Winters

Date 10-31-14

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 Brenda K Winters Date 10-31-14

Printed Name: Brenda K Winters

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

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: November 30, 2011

YOUTH SELF-ATTESTATION FORM
Work Opportunity Tax Credit Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with Form ETA 9061 for each certification request filed.

New Hire Name: Brenda Winters

Social Security Number: 514-64-1814 Date of Birth: 11-21-1956

Employer Name: Employer Solutions Staffing Group

Employer Federal ID (EIN) Number: -

Please check all the statements that apply to you. Sign and date this form where indicated below.

☐ In the past 6 months, I have not attended a secondary, technical or postsecondary school for more than an average of 10 hours per week, not counting periods during which the school is closed for scheduled vacations.

☐ I do not have a High School Diploma or GED certificate.

☐ I have a High-School diploma or GED certificate awarded more than 6 months ago and I have not attended or been admitted to a technical or post-secondary school. I also have not held a job (other than occasionally) since receiving my High-School diploma or GED certificate.

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

New Hire's Signature: Brenda Winters Date 11-13-2014

Privacy Act Notice:
The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form, including the Social Security Number, will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OM B control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of Adult Services, Room S-4209, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.