

CORPORATE MANAGEMENT GROUP

Employment Application

Office Hours: 9am-4pm Mon-Fri

Office Number: 651-666-3883

Office Address: 404 Broadway Ave St. Paul Park, MN 55071



Applicant Information

(APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS AND A BACKGROUND CHECK WILL BE COMPLETED)

Please fully complete pages 1-3

Full Name: (Last Name, First Name) MARU, Hebrone Date: Jan. 11, 18

Address: (Street Address) 12 West 22nd St. (Apt./Unit #) 105

(City) Minneapolis (State) MN (ZIP Code) 55404

Phone: 651-398-0373 Email: hebrone.maru@gmail.com

Social Security No. 849-80-9837 Date Available: _____

Position Applied for: _____ Desired Salary: _____

Shift Available to work: 1st 2nd 3rd Employment desired: Full-Time Part-Time

What is your means of transportation to work? Car

Are you authorized to work in the U.S.? Yes No

How did you hear about us? Online Referral Name: _____

If under 18, please list age: _____

Education				
Type of School	Name of School	Location (Complete Mailing Address)	Number of Years Completed	Major & Degree
High School	Roosevelt High School	Mpls	4	
College				
Bus. Or Trade School				
Professional School				

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Previous Employment

Company: O+G Mary. Phone: _____
Address: Mpls/st-paul airport Supervisor: James
Job Title: Line Cook Starting Salary: \$13.75 Ending Salary: \$14.75
Responsibilities: Cook, clean, prep cook
From: 3/16 To: 11/16 Reason for Leaving: not enough hrs.
May we contact your previous supervisor for reference? Yes No

Company: Perkin Phone: _____
Address: Minneapolis Supervisor: Sen
Job Title: Line Cook Starting Salary: \$10.50 Ending Salary: \$12.50
Responsibilities: Open / close Cook, clean
From: 12/10 To: 01/12 Reason for Leaving: I move states
May we contact your previous supervisor for reference? Yes No

Company: _____ Phone: _____
Address: _____ Supervisor: _____
Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____
Responsibilities: _____
From: _____ To: _____ Reason for Leaving: _____
May we contact your previous supervisor for reference? Yes No

Company: _____ Phone: _____
Address: _____ Supervisor: _____
Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____
Responsibilities: _____
From: _____ To: _____ Reason for Leaving: _____
May we contact your previous supervisor for reference? Yes No

I certify that my answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

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PLEASE READ CAREFULLY APPLICATION FORM WAIVER

In exchange for the consideration of my job application by Corporate Management Group, Inc.,

I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements and the like as they may exist from time to time, or other company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of Corporate Management Group, Inc. (CMG), or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by an officer of CMG. Both the undersigned and CMG may end the employment relationship at any time, without specified notice or reason. If employed, I understand that CMG may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination. I hereby give CMG permission to contact schools, all previous employers (unless otherwise indicated), references and others and hereby release CMG from any liability as a result of such contact.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by CMG. 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 CMG policies.

I release CMG and other persons or entities from any claims that might be based on CMG's decision to conduct a background check.

I understand that, in connection with the routine processing of your employment application, CMG may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics and mode of living. Upon written request from me, CMG will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with CMG shall be probationary for a period of ninety (90) days and further that at any time during the probationary period or thereafter, my employment relationship with CMG is terminable at will for any reason by either party.

Signature of applicant

Date:

01/11/18



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name) MARU		First Name (Given Name) Hebrome		Middle Initial M.	Other Last Names Used (if any) _____	
Address (Street Number and Name) 12 West 22nd St.			Apt. Number 105	City or Town Minneapolis		State MN
Date of Birth (mm/dd/yyyy) 12-19-87		U.S. Social Security Number 349-80-9837		Employee's E-mail Address hebromemaru@gmail.com		Employee's Telephone Number 651-398-0373

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input checked="" type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident <i>(Alien Registration Number/USCIS Number):</i> _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ <i>Some aliens may write "N/A" in the expiration date field. (See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> QR Code - Section 1 Do Not Write In This Space </div>	

Signature of Employee 	Today's Date (mm/dd/yyyy) 1-11-18
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Preparer and/or Translator Certification (check one):

I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

STOP *Employer Completes Next Page* STOP

5442816724

**REPLICATION
NOT A DRIVER'S LICENSE**

KERROWE MELBA WARD
12 W 22ND ST #200
MINNEAPOLIS MN 55405

Date of Birth: 12-15-1947
Sex: F
Height: 5'00"
Weight: 120
Eyes: BRN
Hair: BRN
Complexion: F
M. A. J. J.

Expires 12-15-2011

**LICENSE/ENHANCED DRIVER'S LICENSE
INSTRUCTION PERMIT APPLICATION
APPLICATION RECEIPT**

2018702009071

STANDALONE IDENTIFICATION DOCUMENT

IN CARD NUMBER: 312 BIRTH DATE (MONTH/DAY/YEAR): 12/19/87

IDDLE NAME: LAK COMPLETE LAST NAME: MARU
 (MIN DRIVER'S LICENSE, EDL, ID OR IP APPLICATION)

IDDLE NAME: [REDACTED] COMPLETE LAST NAME: [REDACTED]

OR CURRENT AND VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD.
 ST Apt# 105
 STATE: MN ZIP CODE: 55101 MN COUNTY: 27

IF THIS IS A VALID ADDRESS. THE POST OFFICE WILL NOT FORWARD YOUR CARD.
 ADDRESS SHOWN ABOVE, INITIAL HERE TO HAVE YOUR CARD SENT TO THE ADDRESS BELOW.
 Apt# [] STATE: [] ZIP CODE: [] MN COUNTY: []

WEIGHT IN POUNDS: 245 MALE: [X] FEMALE: []

TYPE <input checked="" type="checkbox"/> REG <input type="checkbox"/> EDL <input type="checkbox"/> A <input type="checkbox"/> DUP <input type="checkbox"/> B <input type="checkbox"/> DUP <input type="checkbox"/> C <input type="checkbox"/> DUP <input type="checkbox"/> D <input type="checkbox"/> DUP <input type="checkbox"/> PROV <input type="checkbox"/> DUP <input type="checkbox"/> ID <input type="checkbox"/> DUP <input type="checkbox"/> MBOP <input type="checkbox"/> DUP <input type="checkbox"/> CLP <input type="checkbox"/> REG IP INDICATORS <input type="checkbox"/> SENIOR <input type="checkbox"/> LTD MOBILITY <input type="checkbox"/> SNOWMOBILE <input type="checkbox"/> FIREARM <input type="checkbox"/> S or TC <input type="checkbox"/> VETERAN	RX # TESTS PASSED (STATE EXAM USE ONLY) <input type="checkbox"/> D <input type="checkbox"/> MC <input type="checkbox"/> MBOP <input type="checkbox"/> GK <input type="checkbox"/> AIR <input type="checkbox"/> COMB <input type="checkbox"/> DBL/TRIPLE <input type="checkbox"/> PASSENGER <input type="checkbox"/> SCHOOL BUS <input type="checkbox"/> TANKER <input type="checkbox"/> HAZMAT <input type="checkbox"/> DWI <input type="checkbox"/> RT Passed <input type="checkbox"/> RT Waived	RESTRICT/ENDORSE <input type="checkbox"/> MC ORIGINAL <input type="checkbox"/> MC RENEWAL <input type="checkbox"/> ADD/REMOVE FEES PAID APPLICATION: \$ 10.25 OTHER FEES: MG: \$ SB PHYS: \$ REIN FEE: \$ OTHER: \$ ORGAN DONATION: \$	VISION <input type="checkbox"/> PASS NR <input type="checkbox"/> PASS WITH CL <input type="checkbox"/> INCOMPLETE <input checked="" type="checkbox"/> ATTACHED: PROPER ID <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO MW ID INVALIDATED DL ID/IP: [] STATE: MN Exp: 12-10
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Notes: Renewal

I was provided all privacy warnings as required by state and federal law. Submission of this application constitutes consent to registration with the selective service system, if required by federal law. I certify that the information on this application is correct. If I am applying for driving privileges, I am aware of the duties, responsibilities, and penalties outlined in M.S. § 169.444 regarding the safety of children around school buses.

X [Signature] - Applicant Signature Application Date: 1/9/13

Apply to: Remove (DVS USE ONLY)
 Driving privileges
 Chicago LL
 Contact Us:
 651-297-3298
 651-284-1234
 651-297-2005
 651-297-2126
 651-282-6555

PAID
 JAN - 9 2013
 Deputy 140

THIS DOCUMENT IS A RECEIPT FOR THE TYPE OF CARD INDICATED, AND IS NOT A STANDALONE IDENTIFICATION DOCUMENT

- This receipt, in conjunction with an invalidated previous license, instruction permit or ID card, may be used as identification.
- This receipt is valid for the type of card indicated, when stamped with the proper validation stamp, for a maximum of 60 days from the application date shown above.
- This receipt is void if the applicant is not in compliance with all restrictions indicated on the driving record.
- **Not valid as Enhanced Driver's License (EDL) for border crossings.**
- **Lost, stolen and duplicate EDL cards are deactivated and may not be used for border crossings.**

PLEASE READ THIS NOTICE BEFORE YOU COMPLETE THE APPLICATION

NOTICE

Information and how will it be used?

How will the information be used?

The information will be used to identify you as a person, to identify your eligibility for a driver's permit, license or identification card, and for any future service transactions and/or inquiries, and to

Collection of this information.

Minnesota Statutes, sections 169.01 and 169.02, and federal motor carrier safety regulations require the collection of this information.

How to supply requested information.

DPS will be able to determine whether to issue you a driver's permit, license, or identification card. The requested information will be used by other states to make decisions regarding issuance of a driver's permit, license, or identification card. The requested information will also be used to determine eligibility for automobile insurance coverage.

If you do not provide the requested information, DPS cannot issue you a driver's permit, license, or identification card, and your driving privileges, if any, may be affected.

Information shared with other agencies?

The information will be shared with other state, federal, and federal government agencies only as authorized or permitted by law. Means that the information may be shared with the following:

MN Department of Commerce
MN Attorney General's Office
MN Office of the Secretary of State
MN Department of Natural Resources
MN Department of Veterans Affairs

The information may also be disclosed as authorized by United States Code, title 18,

Other uses.

Your Social Security number according to M.S. § 171.06 and the Social Security Act. Your Social Security number is also required to determine your eligibility for federal motor carrier safety regulations, 49 C.F.R. § 383.153. The information will be used in enforcement programs and locate individuals to establish identity and residential address with the Social Security Administration, the Internal Revenue Service, Minnesota Department of Revenue, the Internal Revenue Service, Minnesota Department of Human Services.

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

- For use by any government agency, including any court or law enforcement agency, in carrying out its functions, or any private person or entity acting on behalf of a federal, state, or local agency in carrying out its functions.
- For use in connection with matters of motor vehicle or driver safety and theft; motor vehicle emissions; motor vehicle product alterations, recalls, or advisories; performance monitoring of motor vehicles, motor vehicle parts, and dealers; motor vehicle market research activities, including survey research; and removal of non-owner records from the original owner records of motor vehicle manufacturers.
- For use in the normal course of business by a legitimate business or its agents, employees, or contractors, but only:
 - (A) to verify the accuracy of personal information submitted by the individual to the business or its agencies, employees, or contractors; and
 - (B) if such information as so submitted is not correct or is no longer correct, to obtain correct information, but only for the purposes of preventing fraud by, pursuing legal remedies against, or recovering on a debt or security interest against, the individual.
- For use in connection with any civil, criminal, administrative, or arbitral proceeding in any federal, state, or local court or agency or before any self-regulatory body, including the service of process, investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, or pursuant to an order of a federal, state, or local court.
- For use in research activities, and for use in producing statistical reports, so long as the personal information is not published, re-disclosed, or used to contact individuals.
- For use by any insurer or insurance support organization, or by a self-insured entity, or its agents, employees, or contractors, in connection with claims investigation activities, antifraud activities, rating, or underwriting.
- For use in providing notice to the owners of towed or impounded vehicles.
- For use by any licensed private investigative agency or licensed security service for any purpose permitted under this subsection.
- For use by an employer or its agent or insurer to obtain or verify information relating to a holder of a commercial driver's license that is required under the Commercial Motor Vehicle Safety Act, 49 U.S.C. §§ 31301-17.
- For use in connection with the operation of private toll transportation facilities.
- For any other use in response to requests for individual motor vehicle records if the state has obtained the express consent of the person to whom such personal information pertains.
- For bulk distribution for surveys, marketing, or solicitations if the state has obtained the express consent of the person to whom such personal information pertains.
- For use by any requester, if the requester demonstrates it has obtained the written consent of the individual to whom the information pertains.
- For any other use specifically authorized under the law of the state that holds the record, if such use is related to the operation of a motor vehicle or public safety.

STATE OF ILLINOIS }
County of Cook,

S.

DAVID D. ORR. County Clerk

I, DAVID D. ORR, County Clerk of the County of Cook, in the State aforesaid, and Keeper of the Records and Files of said County, do hereby certify that the attached is a true and correct copy of the original Record on file, all of which appears from the records and files in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Seal of the County of Cook, at my office in the City of Chicago, in said County.

David D. Orr
County Clerk

Type or Print in
PERMANENT INK
See Instructions
or Physicians
Handbook for
INSTRUCTIONS

MATCHING IBC		STATE OF ILLINOIS		CHILD'S BIRTH NUMBER	
REGISTRATION DISTRICT NO 16.10		CERTIFICATE OF LIVE BIRTH 112-87 651306			
REGISTERED NUMBER					
1 CHILD - NAME		FIRST MIDDLE LAST		DATE OF BIRTH (MONTH, DAY, YEAR)	
2 KEBROME MELAK MARU				26 December 19, 1987	
CHILD		HOURS MIN. SEC. SEX		HOSPITAL - NAME	
3 12:26 P M Male				4b Columbus Hospital	
CITY TOWN TWP OR ROAD DISTRICT NO		COUNTY			
4b Chicago		4c Cook			
4 Q315 MOTHER - MAIDEN NAME		FIRST MIDDLE LAST		AGE (AT TIME OF THIS BIRTH)	
5a Nunu K. Sega				5b 27	
RESIDENCE		CITY TOWN TWP OR ROAD DISTRICT NO		INSIDE CITY (YES/NO)	
6a 850 W. East Wood		6b Chicago		6c Yes	
MOTHER'S COMPLETE MAILING ADDRESS		CITY OF BIRTH		STATE	
7 850 W. East Wood Apt. #507 Chicago Illinois 60640					
FATHER - NAME		FIRST MIDDLE LAST		AGE (AT TIME OF THIS BIRTH)	
8a Melak G. Maru				8b 31	
RESIDENCE		CITY TOWN TWP OR ROAD DISTRICT NO		INSIDE CITY (YES/NO)	
9a Chicago				9c Yes	
CITY OF BIRTH		STATE			
9b Chicago Illinois					
I CERTIFY THAT THE PERSONAL INFORMATION CONTAINED ON THIS CERTIFICATE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF		SIGNATURE		RELATION TO CHILD	
		10a <i>Quanita Gonzalez</i>		10b Birth Certificate Registrar	
I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATE ABOVE		DATE SIGNED (MONTH, DAY, YEAR)			
		10c Dec. 20, 1987			
SIGNATURE		ILLINOIS LIC 2888 NO		NAME AND TITLE OF ATTENDANT AT BIRTH (IF OTHER THAN CERTIFIER (YES OR NO))	
10d <i>Farhad Saad, M.D.</i>		10e 49123		10f	
CERTIFIER - NAME AND TITLE (YES OR NO)		MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)			
10g Farhad Saad, M.D.		10h 850 W. Irving Chicago, IL 60613			
LOCAL REGISTER SIGNATURE		CHICAGO DEPT. OF HEALTH		HAVE RECEIVED BY LOCAL REGISTRAR (MONTH, DAY, YEAR)	
11a <i>David D. Orr</i>		11b DEC 23 1987			
VENDOR (IF ANY)		ILLINOIS DEPARTMENT OF PUBLIC HEALTH - OFFICE OF VITAL RECORDS		ISSUED ON THE U.S. STANDARD CERTIFICATE	



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification
 (Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "List of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name) <i>Maria</i>	First Name (Given Name) <i>Lebron</i>	MI <i>M</i>	Citizenship/Immigration Status <i>T</i>
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List A		OR	List B		AND	List C	
Identity and Employment Authorization			Identity			Employment Authorization	
Document Title		Document Title	<i>MN State ID (Receipt)</i>	Document Title		<i>Birth Certificate</i>	
Issuing Authority		Issuing Authority	<i>State of MN</i>	Issuing Authority		<i>State of IL</i>	
Document Number		Document Number		Document Number		<i>112-87 651306</i>	
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)	<i>04/23/2018</i>	Expiration Date (if any)(mm/dd/yyyy)			
Document Title		Additional information		QR Code - Sections 2 & 3 Do Not Write In This Space			
Issuing Authority							
Document Number							
Expiration Date (if any)(mm/dd/yyyy)							
Expiration Date (if any)(mm/dd/yyyy)							

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

The employee's first day of employment (mm/dd/yyyy): *01/11/2018* (See instructions for exemptions)

Signature of Employer or Authorized Representative <i>Rachel</i>		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative <i>Recruiter</i>	
Last Name of Employer or Authorized Representative <i>Inchell</i>	First Name of Employer or Authorized Representative <i>Rachel</i>	Employer's Business or Organization Name EMPLOYER SOLUTIONS STAFFING GROUP LLC		
Employer's Business or Organization Address (Street Number and Name) 7480 FLYING CLOUD DRIVE SUITE 200		City or Town EDEN PRAIRIE	State MN	ZIP Code 55344

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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employer solutions staffing group, inc.

Wage Payment Method Authorization (Minnesota)

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

SECTION 1 BASIC INFORMATION

Employee Name Kebrone MAZU

SSN# (last 4 digits) 9837

Effective Date _____

SECTION 2 PAYROLL ELECTION

Direct Deposit (Please complete Sections 3 and 5 below)

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

Note: Direct Deposit accounts may take up to 7 days to be activated

Paper Check (Please complete Section 5 below)

SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: _____

Routing# _____

Account# _____

Account Type: Checking Savings Other _____

I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.

Initial _____ Date _____

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

SECTION 4 PAYROLL DEBIT CARD

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.

Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)

First Name _____

M.I. _____

Last Name _____

Street Address (PO BOX NOT ACCEPTABLE) _____

Date of Birth _____

City _____

State _____

Zip _____

Cell Phone (mobile) _____

Social Security# _____

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

Payroll Debit Card Routing # _____

Payroll Debit Card Account # _____

I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature: _____

Date: _____

SECTION 5 AUTHORIZATION

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

*E-mail: Kebrone MAZU @gmail.com

this information will only be used to send your paystubs electronically

Employee's Signature: Kebrone MAZU

Date: 01-11-18

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Notes: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- is age 65 or older,
- is blind, or
- will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

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

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

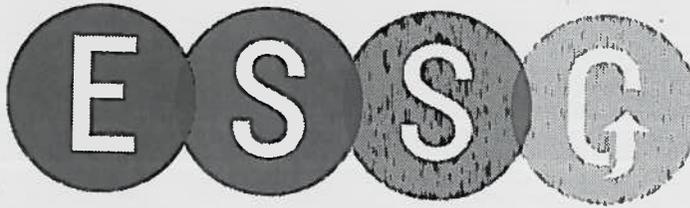
Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u>1</u>
B	Enter "1" if: <ul style="list-style-type: none"> • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B	<u> </u>
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u> </u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u>3</u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	<u> </u>
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child. 	G	<u> </u>
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶	H	<u>4</u>

For accuracy, complete all worksheets that apply.
 • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
 • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

Form W-4		Employee's Withholding Allowance Certificate		OMB No. 1545-0074
Department of the Treasury Internal Revenue Service		▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		2017
1 Your first name and middle initial Kebrone M.		Last name MARU		2 Your social security number 349-80-9837
Home address (number and street or rural route) 12 West 22nd St. (APT #105)		3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code Minneapolis MN 55401		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1215 for a replacement card. ▶ <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 <u>4</u>		
6 Additional amount, if any, you want withheld from each paycheck		6 \$ <u> </u>		
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ <input type="checkbox"/>				
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (This form is not valid unless you sign it.) ▶ <i>[Signature]</i>		Date ▶ 01-11-18		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)



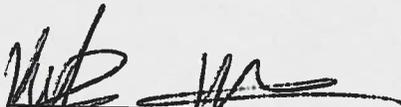
employer solutions staffing group_{uc}

**Notification of Minnesota Law Requirement –
Unemployment Acknowledgement**

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

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

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


Employee Signature:

01-11-13
Date:

Kebrone MAcu
Employee (please print your name here)

**DRUG AND ALCOHOL
TESTING CONSENT FORM**

1. I have been allowed to read and inspect a written copy of ESSG policy on drugs and alcohol.

2. I have read the entire contents of this policy and I am aware and fully understand: (a) the policy and its contents; (b) what conduct the policy prohibits and the consequences of such conduct; (c) my rights under the policy and the consequences if I exercise certain rights; and (d) that certain events as described in the policy may result in adverse personnel action, including my termination from employment with ESSG. I understand that this policy in any form, and any employee handbook including this policy, are not a unilateral employment contract or offer thereof.

3. I hereby voluntarily consent to ESSG, or its health service providers, or other persons or entities acting for or with them, to collect a body component (blood, urine, breath, or any combination thereof) from me for testing for alcohol and/or drugs. I understand that the laboratory selected by ESSG may conduct testing and other analysis on the sample provided by me. I further voluntarily consent to the laboratory's disclosure to ESSG of the results of my drug and/or alcohol test and other information related to the test.

Hebrome, MATEU
Individual's Name

01-11-18
Date

SIGN THIS VERSION OF CONSENT—SAME AS PAGE 6



ATTENTION ALL EMPLOYEES:

At the start of each shift, you are provided with a SuperMom's shirt (stock shirt) and/or smock that is to be worn during your shift. ~~These CANNOT be taken home. They are SuperMom's~~ property, and will be treated as theft if you are seen leaving the facility with the shirts/smocks.

In the lunchroom, SuperMom's provides you with free baked goods that are for you to enjoy and take home. The policy of taking food with you is limited to ONE bag per person. If you are seen leaving the facility with more than one bag of product this will also be considered theft.

If you are seen violating either one of these policies, it will result in immediate termination of employment.

By signing below, you are acknowledging that you understand the above written policies and consequence.

ATENCION TODOS EMPLEADOS:

Al empleo de cada turno usted prestara una camiseta de Super Mom's o un delantal que se necesita usar durante su turno. Estos articulos NO PUEDEN llevarse a la casa. Son propiedad de Super Mom's y sera tratado como robo si usted se los lleva fuera del edificio.

En el cuarto de rotura, Super Mom's le ofrece panecillos que son para que usted disfrute y lleve a su casa. La poliza de llevarlos a su casa es limitado a UNA bolsa por persona. Si usted lleva mas de una bolsa de estos productos, tambien sera considerado robo.

Si usted viola cualquiera de estas polizas, resultara en despedida inmediata.

Firmar la siguiente linea nos demuestra que usted entiende estas polizas y sus consecuencias.

[Handwritten Signature]
Signature of Employee/Firma de Empleado

~~01-11-18~~ 01-11-18
Date/Fecha

hebrone MAHEU
Printed Name of Employee/Nombre del Empleado



To: Corporate Management Group (CMG) Employees

From: Corporate Management Group

Subject: Attendance Policy

In acceptance of employment with Corporate Management Group (CMG), it is our obligation to inform you of our attendance policy. Each employee is important to the success of the company and the customers we service. We rely on employees to be conscientious and punctual in regards to attendance and deadlines. Therefore, it is important that employees report to work each day as scheduled.

I acknowledge by my signature below that I have been;

- a.) Informed and provided a copy of the attendance policy
- b.) Agree to abide by the policy terms

A: Todos Empleados de Corporate Management Group (CMG)

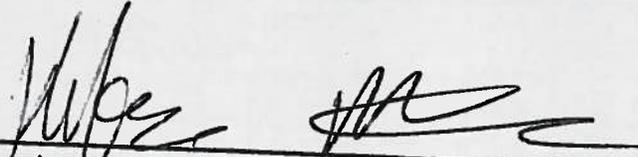
De: Corporate Management Group

Sujeto: Política de Asistencia

En la aceptación de un empleo con el Grupo de Gestión Empresarial (CMG), que es nuestra obligación para informarle de nuestra política de asistencia. Cada empleado es importante para el éxito de la compañía y los clientes a los que el servicio. Contamos con empleados a ser consciente y puntual en lo que respecta a la asistencia y los plazos. Por lo tanto, es importante que los empleados se presenten a trabajar cada día como estaba previsto.

Reconozco con mi firma que he sido;

- a.) Informado y facilitado una copia de la política de asistencia
- b.) Estar de acuerdo en cumplir con los términos de política


(Employee Signature/Nombre de Empleado)

01-11-18
(Date/Fecha)

Acknowledgement of Receipt Antiharassment Policy

I certify that I have received a copy of Employer Solutions Staffing Group's Antiharassment Policy. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone Employer Solutions Group (ESSG) at **952.835.1288/1.866.496.7573** with any questions I may have about this policy. I agree to comply with ESSG's policy on Antiharassment and understand failure to comply is grounds for disciplinary action, up to and including termination.

I also agree that if at any time during my employment I am involved in any employment dispute or I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, marital, sexual orientation or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact my supervisor, manager, director or ESSG's Human Resource Department at **952.835.1288/1.866.496.7573** in order to obtain assistance in the resolution of such matters.

Employee Name (Please Print)

Hebrome, Marc

Employee's Signature:

[Handwritten Signature]

Date: 01-11-18

RECEIPT OF EMPLOYEE HANDBOOK AND EMPLOYMENT-AT-WILL STATEMENT

This is to acknowledge that I have read the Employer Solutions Staffing Group LLC Temporary Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities and obligations of my employment with the company. I understand and agree that it is my responsibility to abide by the rules, policies and standards set forth in the Handbook.

I also acknowledge that my employment with ESSG is not for a specified period of time and can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no manager or employee has the authority to enter into an employment agreement, express or implied, providing for employment other than at-will.

I also acknowledge that, except for the policy of at-will employment, ESSG reserves the right to revise, delete and add to the provisions of this Employee Handbook. All such revisions, deletions or additions must be in writing and must be signed by the CEO of the company. No oral statements or representations can change the provisions of this Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company, with or without cause or notice, at any time. No implied contract concerning any employment-related decision, term of employment or condition of employment can be established by any other statement, conduct, policy or practice.

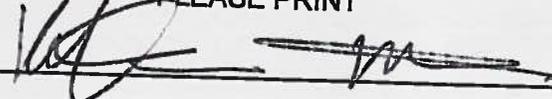
I understand the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and ESSG concerning the duration of my employment, the circumstances under which my employment may be terminated and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings and representations concerning my employment with the company.

If I have questions regarding the content or interpretation of this Handbook, I will bring them to the attention of ESSG.

DATE 01-11-18

EMPLOYEE NAME Kebrone Maru

PLEASE PRINT

EMPLOYEE SIGNATURE 

ESSG REPRESENTATIVE Kayla Hollaway



ACKNOWLEDGMENT

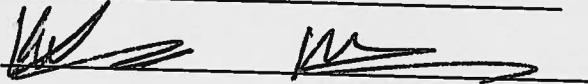
The associate handbook was reviewed with me, and I have received my personal copy. I also acknowledge that I have been given the opportunity to ask questions and express concerns during my orientation. Additionally, I understand and support the following:

1. This handbook is intended as a guide and **not** an employment agreement that creates a contractual relationship, and that the employment relationship may be terminated at the will of either party at any time.
2. The changing needs of the business will require alteration in method, practices and policies, and the company will unilaterally revise, as necessary, to meet these changing needs.
3. I agree to **notify** my ESSG Consultant **immediately** of any change in my personal data such as phone number, address, emergency notification, etc.
4. I am responsible for the information provided herein and will, upon my separation, return this handbook to my ESSG Consultant.

Date:

01-11-18

Associate's Signature:



Associate's Printed Name:

Kebrone Maren

Orientation provided by:

Kayla Holloway

Enhanced MEC Plan Plan 1

Benefits Enrollment Form New Employee Rehire Rehire Date

Employee Information	
Name (First and Last)	Social Security Number
Address	City State Zip Code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Date of Birth	Date of Hire
Phone Number:	Email Address:

Please Select Desired Coverage:

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

Dependent				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Dependent				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Dependent				
First Name	M.I.	Last Name	Social Security #	Birth Date
			Sex	Relationship
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

EFF. DATE

EFF. DATE

EFF. DATE

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

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature _____ Date _____

EMPLOYEES DECLINING I am DECLINING coverage

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

IF DECLINING - YOU MUST SIGN HERE

Employee Signature *[Signature]* Date *01-11-18*

Fixed Indemnity Medical Benefits Plan 2

VSI **219301-ESG-1** OFFICE USE ONLY LOCATION _____ Rehire Date ___/___/___

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name _____ Social Security # _____ Home Phone _____ Sex M F

Address _____ Apt. # _____

City _____ State _____ Zip _____ Date of Birth ___/___/___

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?

Yes No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN) _____ Medicare Effective Date _____

Name of Covered Person (s):

1. _____ 2. _____ 3. _____

C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rates

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

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

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

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

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

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

E. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

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

DATE 01/11/2018

► SIGNATURE