ESMAR MANAGEMENT GROUP

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Applicant Name_____

First Middle Last

Street Address_____ Apartment/Unit #_____

City_____ State_____ ZIP Code_____

Phone 1:_____ Phone 2:_____

Email:_____

Employment Positions

Position(s) Applying For_____

What Days And Hours are you Available for Work_____

Can you work weekends? **YES** ◯ **NO** ◯ Are you available to work overtime? **YES** ◯ **NO** ◯

Do you have any friends, relatives or acquaintances working for company? **YES** ◯ **NO** ◯

If yes, state name & relationship? _____

If hired, do you have your own transportation to/from work? **YES** ◯ **NO** ◯

If hired, would you be able to present proof of your eligibility to work in the United States? **YES** ◯ **NO** ◯

If hired, are you willing to submit to and pass a controlled substance test? **YES** ◯ **NO** ◯

Are you able to perform the essential functions or the job for which you are applying, either with/without reasonable accommodation? **YES** ◯ **NO** ◯

If No, describe the functions that cannot be performed:_____

(Note: Company complies with the ADA and consider reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. It is possible that a hire may be tested on skill/agility and may be subject to a medical examination conducted by a medical professional.)

Education, Training and Experience

School Name:_____

School Address:_____

Number of Years Completed_____ Did you Graduate? **YES** ◯ **NO** ◯ Degree/Diploma Earned:_____

Work History

Employer Name:_____ PHONE:_____ Dates of Employment:_____

Job Duties:_____

Reason for Leaving:_____ Supervisor's Name:_____

Employer Name:_____ PHONE:_____ Dates of Employment:_____

Job Duties:_____

Reason for Leaving:_____ Supervisor's Name:_____

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Work References:

Name:_____ Phone:_____ Email:_____

Name:_____ Phone:_____ Email:_____

Name:_____ Phone:_____ Email:_____

Disclaimer and Signature:

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:**_____

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Employment Agreement

FOR OFFICE USE ONLY

Client Name:_____ **Client ID:**_____

Client Address:_____

City:_____ State:_____ Zip Code:_____

Client Phone Number:_____ Alternate Number:_____

Start Date:_____ W/C Code:_____ Rates(s) Pay:_____

Rate(s) by:_____ Overtime Rate(s) of Pay:_____ Regular Pay Day:_____

APPLICANTS COMPLETE BELOW

Military Veteran: **YES** ◯ **NO** ◯ Allowances:_____

Applicants Name:_____ Social Security:_____

Applicant's Address:_____ City:_____ Sate:____ Zip:_____

Applicant's Phone Number:_____ Alternative Number:_____

In case of emergency, please notify:

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone Number:_____

EEO-1 Report Information

The following information pertains to applicable federal EEO-1 Reports. Information received will not be used in any way to evaluate the employee.

Check One Below:

Male: ◯ Female: ◯

White: ◯ Black: ◯ Hispanic: ◯ Asian or Pacific Islander: ◯ American Indian: ◯

Native Hawaiian: ◯ Other: ◯ Two or More Races: ◯

Marital Status: Married: ◯ Married (withhold a higher single rate): ◯ Single: ◯

Employee Initial Here_____

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Welcome to ESMAR Management Group (Here in after "ESMAR Management Group"). The Company for which Issues your paychecks, process your year end, W2 and to offer a variety of Employee benefits for your consideration. Under this agreement, you will be considered an employee of ESMAR Management Group. All information contained in the employment agreement is Important to your employment with ESMAR Management Group. All blanks must be completed, and you must sign the agreement, including the 19 and W4. A copy of your social security is requested for employment tax purposes.

Check on of the following:

Official or Manager ◯ Technician ◯ Craft Worker ◯ Professional ◯ Office (Clerical) ◯ Laborer ◯
Operatives ◯ Service Worker ◯

At-Will Employment:

I, the undersigned employee, in consideration of my hiring by ESMAR Management Group as an at-will employee of ESMAR Management Group's, acknowledge and agree to the following: I have been ESMAR Management Group hired as an at-will employee of ESMAR Management Group which is an employee staffing company and there is no contract of employment which exists between me and the client to which I have been assigned, Nor between ESMAR Management Group and me. I understand and agree that either ESMAR Management Group or I can terminate our employment relationship at any time, as I am an at-will employee. I also agree that I may be assigned to an affiliated ESMAR Management Group company and employed by such company at any time at the sole and complete discretion of ESMAR Management Group and without my consent or agreement. I also agree that while I am a staffed employee with ESMAR Management Group , if ESMAR Management Group does not receive payment from client for services which I perform as a staff employee, ESMAR Management Group will still pay me regular hourly rate of pay if I am a non-exempt employee and to pay my full salary if I am a exempt employee even if ESMAR Management Group is not paid by the client to which I am assigned. I have been informed and that I agree that if my assignment with ESMAR Management Group within seventy-two (72) hours for possible reassignment and that unemployment covered by state workers' compensation statutes, and to avoid circumventions of such statutes which might result from suits herby waive and forever release any rights I might have to make claims to bring suits against any clients or customers of ESMAR Management Group or against ESMAR Management Group for damages based upon injuries which are covered under such workers compensation statutes.

Client Company Paid Leave Policies and Other Benefits.

In the case of that Client Company maintains policy providing paid leave benefits such as vacation, sick leave, pto, or severance pay, client company is solely responsible for paying any accrued benefits under such policies during employment and at time of termination. ESMAR Management Group does not provide, and has no policy providing vacation and or other paid leave benefits. To the extent paid leave benefits are paid thru ESMAR Management Group payroll to employee, it is solely as a payroll service on behalf of client company. Similarly, to the extent client company provides other benefits pursuant to policies to which ESMAR Management Group is not a party, such as stock options, bonuses, profit sharing, retirement benefits, and so forth, client company is solely responsible for providing benefits prescribed by those policies.

Assignment.

If Client Company files any form of bankruptcy, employee will and hereby transfers to ESMAR Management Group all of his/her rights as a employee for the purposes of payment of wages and applicable payroll taxes. For this right, ESMAR Management Group will compensate Employee an additional five percent (5%) premium, on those amounts ESMAR Management Group receives from client as a result of the assignment of Employee's rights.

Employee Initial Here:_____

ESMAR MANAGEMENT GROUP

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Policies and Benefits.

Employee agrees to abide by the policies of ESMAR Management Group including but not limited to policies contained in any applicable Employee handbook. Employee understands that eligibility and coverage for ESMAR Management Group benefits is controlled by the terms and conditions of the applicable Plan Documents.

Arbitration:

ESMAR Management Group promotes a voluntary system of alternative dispute resolution that utilities binding arbitration to resolve all disputes that may arise out of the employment context.

Medical Authorization

I hereby authorize the release of any and all medical, hospital vocational and psychological records and other information related to my Injury, illness or worker's compensation claim (hereinafter collectively referred to as "Medical Information") to ESMAR Management Group ; its employees, agents and authorized representatives. I hereby permit ESMAR Management Group to review and obtain copies of any and all Medical Information and to discuss pertinent Medical Information with professionals involved in my health care treatment. Thereby give ESMAR Management Group permission to release the Medical information to healthcare providers, third party administrators, federal or state court, Workers' Compensation Boards, employers Insurers and any other party who may be involved with my claim, treatment or vocational rehabilitation, or as required by law. Further pursuant to Title 42 Section 1395y, carriers are required to share claimants' Medical Information to enable the Centers for Medicare & Medicaid Services, formerly known as Healthcare Financing Administration (CMS) to determine eligibility for benefits. Thereby give ESMAR Management Group Workforce permission to discuss, disclose and release any Medical Information with or to CMS in connection with my claim. I hereby release ESMAR Management Group from any liability or loss due to the release of Medical information. I understand that all information released will be handled confidentially and in accordance with all applicable laws. I also understand that this authorization shall stay in effect until the closure of the claim file. I certify that this authorization has been made. voluntarily and that the Information given herein is accurate to the best of my knowledge. A photocopy of this authorization shall have the same validity as the original.

Accident/Injury Guidelines & Procedures

1. All Injuries must first be reported to your immediate supervisor, who will then report the incident to ESMAR Management Group Workers Compensation Department before authorization will be given for medical treatment. Exception; emergency situations or if the injury occurs after hours and/or on the weekends.
2. A drug screen Is required within 24 hours for all injuries. In accordance with state law, a positive result relieves ESMAR Management Group and Its Insurers from any responsibility for any medical expenses incurred in connection with your injury, Refusal to submit to a drug test will result in the same consequences as a positive drug test result. If an employee tests positive on a post-accident drug test, they will be discharged for violation of the company's substance abuse policy, and workers' compensation benefits and/or medical bills incurred by the employee will be denied.
3. The employee is required to inform the doctor or medical facility that light duty work is available. The Employee will be required to work light duty per the doctor's instructions,
4. Employees are required to forward all medical information associated with the workplace Injury/illness (doctor's work status report, medical records, etc.) within 24 hours
5. Employees are required to complete an Employee Accident/Injury report within 24 hours of the injury/illness.

Employee Initial Here:_____

ESMAR MANAGEMENT GROUP

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

MPN (Medical Provider Network Confirmation

I have received the MPN (Medical Provider Network) I acknowledge that my employer has posted the provider listings for the MPN. I acknowledge that if I do not complete the enrollment forms and return it to my employer within 30 days, my employer will enroll me in the MPN. I acknowledge that this letter pertains to workers' compensation only. This is not a health plan. This applies only to work related injuries or work-related illnesses,

Substance Abuse Policy

Any employee on duly or on company property who possesses, sells, receives, or is determined to have measurable levels of any illegal drug, or sufficient alcohol to Impair performance in their blood or urine, will be subject to immediate discharge, and in appropriate situations, referred to law enforcement authorities. See your Employee Handbook regarding procedures applicable to prescriptive medications. Periodically, unannounced inspections will be made of persons entering or leaving company work sites by authorized company representatives. Entry onto company property is deemed to be consent to an Inspection of a person, locker, vehicle, or any other personal effects. ESMAR Management Group also reserves the right to require employee testing for illegal or controlled drugs or alcohol, based on reasonable suspicion and I as an employee specifically agree to post-accident drug testing in any situation where it is allowed by law.

Deductions

By initialing this page below and signing this employment agreement form I authorize deductions when applicable to be made out of my paycheck for tools, uniforms, health Insurance, errors in payroll, garnishments, overpayments, bank fees for stop payment of a lost or damaged check, and any other work-related deductions. I agree that if I should leave or be discharged from employment at the above client company ESMAR Management Group before the full amount is paid, any earning over minimum wage will be applied to my deduction loan. The amount deducted from my last paycheck may be greater than the amount shown for each paycheck in accordance with the applicable labor law.

Six Hour Meal Period Waiver Agreement

I, hereby agree, by mutual consent of the employer and employee, to waive my required meal period is when a work period of not more than six {6) hours will complete the day's work, as defined by the State of California Industrial Welfare Commission Order, Section 11(A)

Acknowledgement of Meal & Rest Periods Policy

This policy details the meal and rest period policy and process for Nonexempt employees in California, Pursuant to California law, employees who work more than five (5) hours will be provided with at least a full thirty (30) minute meal period. This meal period will begin no later than the fifth hour of work. Additionally, employees who work more than ten:(10) hours in a workday will be provided with a second thirty (30) minute meal period. This second meal period must be taken before the end of the tenth hour of work. Meal periods cannot be taken at the beginning or end of shifts.

Employees will be relieved of all of their duties during meal periods and may not work during this time. An employee's meal period shall not be considered "on duty" and will not be counted as time worked. Employees will be provided ten (10) minute paid rest periods to employees for every four (4) hours worked or major fraction thereof, unless the employee works less than three and a half hours in a day. Employees will be informed by a supervisor when to take their rest periods: Whenever practicable, employees should be able to take their rest breaks near the middle of each four-hour work period. Employees may not accumulate rest periods or use rest periods as a basis for starting work late, leaving their assigned shift early, or extending a meal period, Because rest breaks are paid, employees should not clock out for them. This meal and rest break policy applies at all times during your employment; including while placed on job assignment at any client company in California. I hereby certify that I fully understand this policy and process regarding meal and rest periods and will comply with these rules. If I miss or am unable to take a meal or rest period, I agree to notify my local branch office within twenty-four (24) hours so that my employer can investigate and take the appropriate corrective action.

Employee Initial Here:_____

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Harassment Discrimination and Retaliation Prevention Policy.

Reporting Harassment or Discrimination. If you believe that you have been subjected to or witnessed any unlawful harassment, discrimination, or retaliation, you should immediately report such conduct to your supervisor. If you do not feel comfortable reporting harassment or discrimination to your supervisor, you should report the harassment and or discrimination to ESMAR Management Group Human Resources Employee. In addition, if an employee observes harassment or discrimination by another employee, supervisor, manager, or non-employee, the employee should immediately report the incident to Human Resources Department. Employees notification to ESMAR Management Group is essential to enforcing this policy. Employees may be assured that they will not be penalized in any way for reporting a harassment or discrimination problem. It is unlawful for employers to retaliate against employees who oppose practices prohibited by the California Fair Employment and Housing Act ("FEHA"), or who file complaints or otherwise participate in an investigation, proceeding, or hearing conducted by the California Department of Fair Employment and Housing ("FEHC"). Similarly, ESMAR Management Group prohibits employees from hindering its internal investigations or its Internal complaint procedure. All complaints of unlawful harassment or discrimination that are reported to management or to the Humans Resources Department will be investigated as promptly as possible through a fair and thorough investigation by an impartial qualified ESMAR Management Group Representative. ESMAR Management Group will conduct its investigation in a manner that provides all parties appropriate due process and reasonable conclusions that are based on the evidence collected, including by documenting and tracking its investigation. Corrective action will be taken where warranted and based on the documented evidence. Supervisors and/or managers who witness harassment, discrimination, or retaliation, or who receive reports of harassment, discrimination, or retaliation, must immediately report such conduct to Human Resources Department. Failure to do so for supervisors and/or managers may result in disciplinary action. Violations of this policy will subject an individual to disciplinary action, up to and including immediate termination. Additionally, under California law, employees may be held to be personally liable for harassing conduct that violates the FEHA. Retaliation Prohibited. ESMAR Management Group prohibits retaliation against those who report, oppose or participate in an investigation of alleged violations of this policy. Participating in an investigation of alleged wrongdoing in the workplace includes:

1. Filing a complaint with a federal or state enforcement or administrative agency.
2. Participating in or cooperating with a federal or state enforcement agency that is conducting an investigation of the company regarding alleged unlawful activity.
3. Testifying as a party, witness or accused regarding alleged unlawful activity.
4. Associating with another employee who is engaged in any of these activities,
5. Making or filing an internal complaint with the company regarding alleged unlawful activity.
6. Providing informal notice to the company regarding alleged unlawful activity

ESMAR Management Group strictly prohibits any adverse action or retaliation against an employee for participating in an investigation of alleged violation of this policy. If an employee feels that he or she is being retaliated against, the employee should immediately contact ESMAR Management Group Human Resources Employee. In addition, if an employee observes retaliation by another employee, supervisor, manager or nonemployee, he or she should immediately report the incident to the individuals above. Any employee determined to be responsible for violating this policy will be subject to appropriate disciplinary action, up to and Including termination. Moreover, any employee, supervisor or manager who condones or ignores potential violations of this policy will be subject to appropriate disciplinary action, up to and including termination.

Employee Initial Here:_____

ESMAR MANAGEMENT GROUP

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

Please Check one of the item boxes next to the option in which you would like to designate below:

☐ **I want to enroll in the MPN** (Medical Provider Network) program for my medical care for any work-related injury or illness, I have received information about the HealthCare Organization offered by my employer and want to enroll in the MPN (Medical Provider Network) Program

☐ **I do NOT want to enroll in the MPN**. I want my personal physician, personal chiropractor, or personal acupuncturist to treat me for any related Injury or illness. My personal physician, personal chiropractor or personal acupuncturist is:

(write name and address of your personal physician, personal chiropractor, or personal acupuncturist)

Doctors Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ **I do not want to enroll in the MPN** or designate a personal physician, personal chiropractor, or personal acupuncturist to treat me for any work-related Injury or illness. I understand that my employer will enroll me in the MPN (Medical Provider Network) program for treatment of any work-related injury or illness

WORKER'S COMPENSATION INFORMATION:

Insurance Carrier: _____

Address: _____

Telephone Number: _____ Policy Number: _____

This Employment Agreement form is in compliance with labor LC2810.5

BY SIGNING BELOW, T ACKNOWLEDGE THE RECEIPT OF MY EMPLOYER INFORMATION, MY WAGE INFORMATION, A COPY OF THIS EMPLOYENT AGREEMENT, RECEIPT OF HARASSMENT, DISCRIMINATION AND RETALIATION PREVENTION POLICY, AND MY EMPLOYER'S WORKERS COMPENSATION INFORMATION. BY SIGNING BELOW, ALSO ACCEPT THE TERMS OF THIS EMPLOYMENT.AGREEMENT FORM, ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO COMPLY WITH THE HARASSMENT, DISCRIMINATION, AND RETALIATION PREVENTION POLICY, AND CONFIRM THAT ALL MY PERSONAL AND EMPLOYMENT INFORMATION IS ACCURATE AND CORRECT:

_____	_____
(PRINT NAME of Employee Representative)	**PRINT NAME of Employee**
_____	_____
(SIGNATURE of Employee Representative)	**(SIGNATURE of Employee)**
_____	_____
(Date provided to employee & Signed by Rep)	**(Date Received by Employee & Signed by Employee)**

Forward Your Completed Form to the Human Resource Department *Form: 08/01/2020*

ESMAR MANAGEMENT GROUP

302 S. Milliken Avenue, Suite E2, Ontario, CA 91761

CONSENT TO EMPLOYEE DRUG AND/OR ALCOHOL TESTING

I understand that submission to a Post-Injury Drug And/or Alcohol Screen is a condition of employment with this employer. I understand that should my testing results be confirmed positive or I refuse to test, I will be subject to the company's disciplinary action; including possible discharge, I understand that a tampered with or an adulterated specimen will be considered a refusal to test, resulting in possible discharge.

I hereby give my consent to release the results of my blood and/or urinalysis to the person(s) or department(s) or the specified agent of my employer; Including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment.

I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits. I also understand that a refusal to test, a tampered with or an adulterated specimen under this circumstance may also result in forfeiture of my eligibility for medical and indemnity benefits and immediate action. including possible discharge

By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented, I further authorize the Company to discuss the results with medical personnel / physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administering the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party.

I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review officer.

Employee or Applicant Signature *(Parent or Guardian if Employee is a Minor)*	Print Name	Date
Employee or Applicant SS#	Witness	Date

OR

I hereby refuse to consent to submit testing for the presence of drugs and/or alcohol.

Employee or Applicant Signature *(Parent or Guardian if Employee is a Minor)*	Print Name	Date
Employee or Applicant SS#	Witness	Date

Forward Your Completed Form to the Human Resource Department

Form: 08/01/2020

"During the term of this Agreement, "ESMAR MANAGEMENT GROUP" shall be responsible for payment of wages or other compensation to the Assigned Employees while assigned to Client. Company shall deduct and remit to the proper taxing authority all local, state and federal taxes required of an employer. Based on and in reliance on information provided by Client, Company shall maintain payroll and other wage, benefit and tax records related to the Assigned Employees. Company shall distribute payroll checks to the Assigned Employees on a schedule to be mutually agreed on by Client and Company. Company shall establish a separate, Client specific, bank account in which funds related to the payment of wages to Assigned Employees assigned to Client shall be maintained. Company shall not be responsible for any issues related to the payment of monies from the Client specific bank account including, but not limited to, fraudulent transfers, unauthorized withdrawals, etc. processed by the financial institution with which Company is not otherwise involved. Client agrees to indemnify and hold Company harmless with respect to any claims for non-payment of monies or other claims related to problems associated with the Client specific bank account unless the underlying issue relates to Company's failure to deposit monies sufficient to pay the wages actually owed to the Assigned Employee assigned to Client into the account.

In the event client ends an assigned employee's assignment to Client or if the Assigned Employee's assignment to Client is otherwise ended, Company will ensure that any amounts then owed to the formerly-Assigned Employee will be paid to the formerly-Assigned Employee no later than the following pay period. The formerly-Assigned Employee will continue to be considered for assignment with other Clients, where applicable, and will not be considered to have been terminated for these purposes.

I _____ hereby understand and acknowledge, if assignment to client is ended, any amounts, wages and/ or paychecks, will be processed no later than the following pay period and will considered for assignments with other clients.

Employee Name: _____

Employee Signature: _____

Date:_____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ○ **Single** or **Married filing separately**
○ **Married filing jointly** or **Qualifying surviving spouse**
○ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employment Development Department
State of California

Clear Form

Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City, State, and ZIP Code	Filing Status ☐ Single or Married (with two or more incomes) ☐ Married (one income) ☐ Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (Worksheet A) _____
   - 1b. Number of allowances from the Estimated Deductions (Worksheet B, if applicable.) _____
   - 1c. Total Number of Allowances you are claiming 0
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)** _____

OR

Exemption from Withholding

3. I claim exemption from withholding for 2022, and I certify I meet both of the conditions for exemption. (Check box here) ☐

OR

4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number

Purpose: This certificate, DE 4, is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only**. You must file the state form *Employee's Withholding Allowance Certificate* (DE 4) to determine the appropriate California PIT withholding.

If you do not provide your employer with a withholding certificate, the employer must use Single with Zero withholding allowance.

Check Your Withholding: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

Exemption From Withholding: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating **exempt** must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax withholding on your wages if

(i) Your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) You are present in California solely to be with your spouse; and

(iii) You maintain your domicile in another state.

If you claim exemption under **this** act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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):

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

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.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

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

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 "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Employer's Outsourcing

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
480 W. Alluvial Ave.	Fresno	CA	93650

Section 3. Reverification and Rehires *(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

ESMAR MANAGEMENT GROUP SAFETY QUIZ

Question 1:

Who is the first person to inform you if you have an incident or identify a hazard even if no-one is injured?

- [ ] A) Your supervisor
- [ ] B) The director
- [ ] C) First aider
- [ ] D) Reception

Question 2:

If you are injured at work, no matter how insignificant it is, you must…

- [ ] A) Go home
- [ ] B) Report it to your supervisor
- [ ] C) Go to the hospital
- [ ] D) Tell your family

Question 3:

Slips, trips and falls contribute to 50% of all accidents. What measures can be taken to reduce the risk of injury?

- [ ] A) Keeping all equipment clean and well maintained
- [ ] B) Ensuring walkways remain unobstructed
- [ ] C) Reporting any slip, trip or fall hazards
- [ ] D) All of the above

Questions 4:

If you have an existing illness or condition that requires ongoing medication (e.g, diabetes), whom must you inform?

- [ ] A) Human resources
- [ ] B) Assignment workplace
- [ ] C) General labor
- [ ] D) Esmar Management Group

Question 5:

In your work area who is responsible for your safety at all times?

- [ ] A) Your supervisor
- [ ] B) The director
- [ ] C) Yourself
- [ ] D) Reception

Signature: _____ Date: _____.

NOTICE TO EMPLOYEE

Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: Employer's Outsourcing Inc.

Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? □ Yes □ No

Other Names Hiring Employer is "doing business as" (if applicable):

Esmar Management Group.

Physical Address of Hiring Employer's Main Office:

480 W. Alluvial Ave. Fresno CA, 93650/ 302 S. Milliken Ave. Ste. E2 Ontario CA, 91761

Hiring Employer's Mailing Address (if different than above):

_____

Hiring Employer's Telephone Number: (559)436-6800 / (909)724-4600

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: _____

Physical Address of Main Office: _____

Mailing Address: _____

Telephone Number: _____

WAGE INFORMATION

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

Rate by (check box): ▣ Hour ▣ Shift ▣ Day ▣ Week ▣ Salary ▣ Piece rate ▣ Commission

▣ Other (provide specifics): _____

Does a written agreement exist providing the rate(s) of pay? (check box) □ Yes □ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? □ Yes □ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):

_____

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: _____

WORKERS' COMPENSATION

Insurance Carrier's Name: _____
Address: _____
Telephone Number: _____
Policy No.: _____
□ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _____

PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
   1. requesting or using accrued sick days;
   2. attempting to exercise the right to use accrued paid sick days;
   3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
   4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: *(Check one box)*

☐ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
☐ 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
☐ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.
☐ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption):_____

ACKNOWLEDGEMENT OF RECEIPT

_____ _____
(PRINT NAME of Employer representative) (PRINT NAME of Employee)

_____ _____
(SIGNATURE of Employer Representative) (SIGNATURE of Employee)

_____ _____
(Date) (Date)

The employee's signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.

PPE AGREEMENT/ACUERDO SOBRE EL EQUIPO DE PROTECCIÓN

_____(Name of the employee) agree to use the PPE provided by Esmar Management. The employee authorize Esmar Management to deduct in full the cost from the first check

_____(Nombre del empleado) está de acuerdo en usar el equipaje provisto por Esmar Management Group. El empleado está de acuerdo en que se le descuente el valor total de este equipo en su primer cheque

PPE/EQUIPO	PRICE	EMPLOYEE INITIALS	TODAY'S DATE
Work Boots/Botas			
Hard Hat/Casco			
Safety Vest/Chaleco			
Safety Glasses			
Back Support/Faja			
Gloves/Guantes			

Badge - En el caso de que se la asigne alguna por parte de Esmar o nuestro cliente, deberá ser devuelta al siguiente día de la terminación de su asignación.

Badge Policy. If Esmar Management or our client provides a badge, it must be returned on the following day of the end of your assignment.

Employees Signature/ Firma del empleado: _____

Esmar Representative: _____

Location where the equipment will be used: _____

AUTHORIZATION FOR AUTOMATIC PAYROLL DEPOSIT

Authorization for Direct Deposit - Employee Form This authorizes **ESMAR MANAGEMENT** (the "Company") to send **credit** entries (and appropriate **debit** and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

☐ **New Account**
☐ **Change Account**
☐ **Cancel Account**

Account #1 Type (check one): Checking ☐ Savings ☐ Amount $: _____

Employee's Bank Name: _____

Bank Routing # (ABA#) _____ Account #: _____

Account #2 Type (check one): Checking ☐ Savings ☐ Amount $: _____

Employee's Bank Name: _____

Bank Routing # (ABA#) _____ Account #: _____

IMPORTANT, PLEASE READ:

This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers or a letter from the bank.

IF FUNDS ARE DEPOSITED INTO YOUR ACCOUNT IN ERROR (OVERPAYMENT OR PAYMENT FOR HOURS NOT WORKED) YOU ARE RESPONSIBLE TO RETURN FUNDS TO ESMAR MANAGEMENT WITHIN 24 HOURS. IF FUNDS ARE NOT RETURNED ESMAR MANAGEMENT WILL PURSUE LEGAL ACTIONS.

DIRECT DEPOSITS ARRIVE TO THE ACCOUNTS ON THURSDAYS, BUT OFICIAL PAYDAY IS EVERY FRIDAY, IT WILL BE WEEKS WHEN HOLIDAYS OR TECHNICAL PROBLEMS ARISE, IF THAT IS THE CASE; EXPECT YOUR MONEY ON FRIDAY MORNING.

My signature below indicates that I am agreeing that I am the account holder or have the authority of the cardholder to authorize my employer/company to make direct deposits into the named account. I understand that this authorization will remain in full force and effect until I notify the company in writing that I wish to revoke my authorization and the Company requires at least 5 business days prior to notice to stop, cancel or change this authorization.

EMPLOYEE NAME: _____ DATE: _____

EMPLOYEE SIGNATURE: _____ SSN # _____