

Worksite Employer (Client): _____

Work Location: _____ Work State: _____

NOTE: *45 day notice required for new Location/State*****

NEW EMPLOYEE PACKET

Please complete this packet only ***AFTER*** you have accepted an offer of employment with your Worksite Employer.

Welcome to CoAdvantage! Your Worksite Employer has entered into a relationship with CoAdvantage to provide certain administrative services which typically include: preparation of your paycheck, management of work-related injuries or illnesses via our workers' compensation program, human resources support services and offer certain optional benefits. Your Worksite Employer will continue to have day-to-day direction and control of your employment. Your policies, procedures, pay rate, hours of work and employment practices will remain the responsibility of your Worksite Employer/Company.

Employee Instructions: Complete all items marked in **GREEN**, sign and promptly return to your Worksite Supervisor.

Worksite Employer (Client) Instructions:

- 1) Complete all items marked in **PURPLE**: Page 1; Page 3 - Section 2 "Employer Review and Verification;" and note on Page 8;
- 2) Verify employee has completed packet, including signatures on all forms and acknowledgments; and
- 3) Fax pages 1-8 (front side only) to your Payroll Service Team; and
- 4) Keep the original New Employee Packet for your records. **Note:** pages 3, 7 and 8 should be kept separate from personnel file.

EMPLOYEE PERSONAL INFORMATION

Please **PRINT** your name **exactly** as shown on your Social Security Card:

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security Number (SSN): _____ Date of Birth: ____/____/____

Gender: Male Female Marital Status: Single Married

Home Street Address: _____ Apt/Bldg#: _____

City: _____ State: _____ Zip: _____ County: _____

Email Address: _____

Phone Numbers: Home: (____) _____ Work: (____) _____

Cell (optional): (____) _____

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____

WORKSITE EMPLOYER (CLIENT) ONLY

Employee Date of Hire with Client: ____/____/____ CoAdvantage Start Date: ____/____/____

Job Title: _____ W/C Code: _____ Department: _____ Project: _____

Pay Type: Hourly Salaried Commission Tipped Classification: Non-Exempt Exempt

Status*: Full Time Part Time Seasonal Temporary

(*You are responsible for immediately notifying CoAdvantage of changes in employee status.)

Pay Cycle: Weekly Bi-Weekly Semi-Monthly Monthly

Scheduled Hours _____ Rate of Pay: Standard Rate Rate \$ _____ Per _____

Per Week: _____ Secondary Rate Rate \$ _____ Per _____

Other: _____ Rate \$ _____ Per _____

PTO/Accrual Class/Code: _____ Benefits Class Code (i.e. ABC01)*: _____

(*Required if benefits are administered by CoAdvantage)

Authorized Signature: _____ Title: _____ Date: _____

Form W-4 (2009)

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 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent **A** _____

B Enter "1" if:
 { • You are single and have only one job; or
 • You are married, have only one job, and your spouse does not work; or
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } **B** _____

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** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) **E** _____

F Enter "1" if you have at least \$1,800 of **child or dependent care expenses** for which you plan to claim a credit **F** _____
 (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
 • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then **less "1"** if you have three or more eligible children.
 • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children. **G** _____

H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ► **H** _____

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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$40,000 (\$25,000 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.

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

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">► 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.</p>	OMB No. 1545-0074 2009
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input 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		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____ 6 \$ _____
6 Additional amount, if any, you want withheld from each paycheck		
7 I claim exemption from withholding for 2009, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ► 7 _____		
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ►		Date ►
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)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction

- 1** Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over \$166,800 (\$83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . . **1** \$ _____
- 2** Enter:

{	\$11,400 if married filing jointly or qualifying widow(er)	}	2	\$ _____
	\$ 8,350 if head of household				
	\$ 5,700 if single or married filing separately				
- 3** **Subtract** line 2 from line 1. If zero or less, enter “-0-” **3** \$ _____
- 4** Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) **4** \$ _____
- 5** **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) **5** \$ _____
- 6** Enter an estimate of your 2009 nonwage income (such as dividends or interest) **6** \$ _____
- 7** **Subtract** line 6 from line 5. If zero or less, enter “-0-” **7** \$ _____
- 8** **Divide** the amount on line 7 by \$3,500 and enter the result here. Drop any fraction **8** _____
- 9** Enter the number from the **Personal Allowances Worksheet**, line H, page 1 **9** _____
- 10** **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1** Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1** _____
 - 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than “3.” **2** _____
 - 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3** _____
- Note.** If line 1 is *less than* line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.
- 4** Enter the number from line 2 of this worksheet **4** _____
 - 5** Enter the number from line 1 of this worksheet **5** _____
 - 6** **Subtract** line 5 from line 4 **6** _____
 - 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here **7** \$ _____
 - 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed **8** \$ _____
 - 9** Divide line 8 by the number of pay periods remaining in 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** \$ _____

Table 1

Table 2

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	910	35,001 - 90,000	910
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
18,001 - 22,000	3	19,001 - 26,000	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 26,000	4	26,001 - 35,000	4	330,001 and over	1,280	370,001 and over	1,280
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address <i>(Street Name and Number)</i>		Apt. #	Date of Birth <i>(month/day/year)</i>
City	State	Zip Code	Social Security #

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

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

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature	Date <i>(month/day/year)</i>
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Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address <i>(Street Name and Number, City, State, Zip Code)</i>	
Date <i>(month/day/year)</i>	

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date <i>(if any)</i> : _____		_____		_____
Document #: _____		_____		_____
Expiration Date <i>(if any)</i> : _____		_____		_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address <i>(Street Name and Number, City, State, Zip Code)</i>		Date <i>(month/day/year)</i>

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name <i>(if applicable)</i>	B. Date of Rehire <i>(month/day/year)</i> <i>(if applicable)</i>
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____	Document #: _____	Expiration Date <i>(if any)</i> : _____
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date <i>(month/day/year)</i>
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

**Documents that Establish
Employment Authorization**

	OR	AND
1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form	4. Voter's registration card	
	5. U.S. Military card or draft record	
	6. Military dependent's ID card	5. Native American tribal document
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	6. U.S. Citizen ID Card (Form I-197)
	9. Driver's license issued by a Canadian government authority	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	For persons under age 18 who are unable to present a document listed above:	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Attach a voided check (or copy) for each checking account or a Bank Specification Sheet for savings accounts.				
<input type="checkbox"/> OPTION 1: DIRECT DEPOSIT				
Financial Institution Name	Account Number	Routing Number	Type	Amount
			<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input type="checkbox"/> Net Pay
			<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input type="checkbox"/> \$ _____ <input type="checkbox"/> _____%
			<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input type="checkbox"/> \$ _____ <input type="checkbox"/> _____%
<input type="checkbox"/> OPTION 2: CASH PAY CARD				
Card will arrive in 7-10 business days. A printed check will be provided for a maximum of two pay cycles.				<input type="checkbox"/> Net Pay <input type="checkbox"/> \$ _____ <input type="checkbox"/> _____%
<input type="checkbox"/> OPTION 3: PRINTED CHECK				<input type="checkbox"/> Net Pay

I hereby authorize and request Co-Advantage Resources, Inc. and its affiliates (“CoAdvantage”) to initiate deposit entries into the accounts as indicated above and to initiate adjustments, if necessary, for any entries made in error. I understand that direct deposit will remain in effect until CoAdvantage receives written notification indicating my desire to terminate the service. If I elect to discontinue the service, my notification will occur in such time and in such manner as to afford CoAdvantage a reasonable opportunity to act.

Employee Signature: _____ Date: _____

ACKNOWLEDGEMENT OF GROUP BENEFITS

I understand that I may be eligible or become eligible for certain benefits under the group plans provided by CoAdvantage Resources, Inc. or any of its affiliates or subsidiaries (“CoAdvantage”). Furthermore, I understand, in order for my benefits to be effective, I must complete my assigned benefit wait period and submit the required enrollment forms, including any required documentation, to CoAdvantage prior to my effective date of coverage. I acknowledge that it is my responsibility, and that of my eligible family member(s), to read and understand the various benefit plans presented to me in my Benefit Enrollment Packet. I also understand that I should refer to the summaries of coverage and/or other plan documents for detailed information regarding benefit provisions and that the provisions may be subject to change. I understand that if I enroll under IRS Section 125, my benefit elections will remain in effect until the following annual enrollment unless I experience a qualifying event as discussed below and as further outlined in my benefits packet.

I understand that if I do not receive a Benefit Enrollment Packet during my benefit waiting period, I am responsible for notifying the Benefits Department at CoAdvantage prior to my effective date of coverage. If I am uncertain of my assigned benefit waiting period, I recognize that I am responsible for obtaining confirmation of my assigned benefit waiting period from my worksite employer or CoAdvantage’s Benefits Department. Furthermore, I understand and agree that if I do not return my signed enrollment form to CoAdvantage after I begin working as an eligible employee and before the date my coverage is to be effective, CoAdvantage will consider this a refusal of group coverage. I understand and agree that if I do not elect benefits at the time of my initial eligibility, I will not be permitted to enroll unless a qualifying event occurs. If I experience a qualifying event and would like to enroll, I must notify CoAdvantage and submit the required forms and documentation within 31 days (or 60 days in the case of a newborn child) of my qualifying event or I will not be permitted to make changes or enroll until the following annual enrollment.

I authorize payroll deductions for required employee contributions toward the group benefit plans I have selected. I understand that in the event my employment terminates in the middle of a month, and my worksite employer continues under contract with CoAdvantage, the group benefits I elect will continue until the end of that month. I authorize CoAdvantage to deduct from my final paycheck, as authorized by state and federal law, the employee contribution amounts owed for the final month’s group benefits. I understand that I must meet the eligibility requirements for coverage to be effective.

I have read and acknowledge all statements in this “Acknowledgement of Group Benefits” and authorize all applicable deductions.

Employee Printed Name: _____ SSN: _____

Employee Signature: _____ Date: _____

Employment: I understand that my Worksite Employer (“Employer”) has entered into a Client Service Agreement with CoAdvantage Resources, Inc. or an affiliated company (“CoAdvantage”) whereby CoAdvantage has agreed to provide certain specifically identified employment related services for me and my Employer. I understand that my Employer will still manage, direct and control my day-to-day activities, and that I remain an at-will employee. Employment is considered to be on a trial/probationary basis for the first ninety (90) days after hiring.

Acknowledgment/Disclaimer of Employment Status: I understand I will not be considered a CoAdvantage employee for any purpose until a completed New Employee Packet and required paperwork is fully completed and received by CoAdvantage.

Wages: I acknowledge that my Employer is responsible for paying my wages. In the event my Employer does not pay CoAdvantage for services provided by me to my Employer for any particular pay period, CoAdvantage may terminate the agreement with Employer, with no further obligations to me or my Employer. If the agreement with my Employer remains in place, CoAdvantage may terminate my employment with no further obligations, or may elect to pay me for such pay period no more than the then-current minimum wage rate and my applicable overtime pay based on such minimum wage rate or the minimum salary for that pay period, as permitted by law. I understand that my Employer remains ultimately obligated to me for any unpaid wages I may be due. In the event that my Employer files a petition in bankruptcy at a time when monies are due to CoAdvantage from my Employer for wages paid to me, I hereby assign CoAdvantage any and all rights I have to assert a priority wage claim in the bankruptcy proceeding. I also authorize CoAdvantage and its affiliates to initiate any adjustments on future wages for any entries made in error.

Unemployment: I hereby agree to notify CoAdvantage in the event I resign or am terminated by my Employer, regardless of the reason.

Safety/Injuries: I agree to immediately report to CoAdvantage and my Employer any accidents or injuries I suffer while working or while on my Employer’s premises. I further agree to follow all safety rules and regulations established by either CoAdvantage or my Employer and realize that failure to do so may alter any workers’ compensation benefits provided to me.

Drug Testing: I understand that CoAdvantage or my Employer may now have, or may establish, a drug-free workplace or a drug and/or alcohol testing program consistent with applicable federal, state, or local law. I understand that, pursuant to the Employer’s policy and federal, state, or local law, I may, as a condition of hire or continued employment, be subject to urinalysis and/or blood screening or other medically recognized tests designed to detect the presence of alcohol or controlled drugs. I also understand that I may be subject to an alcohol and/or drug test before any treatment of a work-related accident or injury. I understand that refusal to submit to an alcohol and/or drug test may be considered a positive test result and/or grounds for termination.

Background Check: I understand that all information contained in this employee packet is subject to verification. In the event my Employer requires a complete background and/or credit check, I authorize and consent, to the extent permitted by federal, state and local law, to allow my Employer, CoAdvantage, or their respective agent(s) to obtain information including, but not limited to, motor vehicle reports (driving records), credit history, employment or educational references, criminal history, and any other information concerning me.

Authorization Release: I hereby authorize any party or agency contacted by my Employer, CoAdvantage, or their respective agent(s) to furnish information requested. I understand that I may be required to complete additional releases authorizing my Employer or its agent(s) to investigate all statements contained in this or any other employment related documents. I hereby release, discharge, and hold harmless, to the extent permitted by federal, state, and local law, my Employer, CoAdvantage, their respective agent(s), and any party delivering information to them pursuant to this authorization from any liabilities, claims, charges, or causes of action that I may have as a result of the gathering, delivery or disclosure of any requested information.

Part-Time or On-Call Employees Only (Initial if Applicable): I understand and acknowledge that my employment status with my Employer will be “Part-Time” and/or “On-Call,” and there will be no guarantee of how many hours I will be assigned and/or work in any given workweek.

Employee Certification

I hereby certify that all information contained in this employee packet or in any other application, résumé, or document provided to my Employer or CoAdvantage is true, accurate and complete, and is provided knowingly and voluntarily. I understand that providing any false, inaccurate or incomplete information may result in disciplinary action, up to and including termination of my employment.

Employee Printed Name: _____ SSN: _____

Employee Signature: _____ Date: _____

(1) I have received my copy of the Employee Handbook (the "Handbook") for CoAdvantage and my worksite employer.

I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures contained in the Handbook. I understand that violations of the policies in this Handbook may result in disciplinary action, up to and including termination of employment.

(2) I UNDERSTAND THAT THE HANDBOOK IS NOT AN EMPLOYMENT CONTRACT, BUT SERVES AS A GUIDELINE ONLY. I UNDERSTAND THAT UNLESS I HAVE A WRITTEN EMPLOYMENT CONTRACT WITH MY WORKSITE EMPLOYER (SUCH EMPLOYMENT CONTRACTS ARE NOT BINDING ON COADVANTAGE) PROVIDING OTHERWISE, MY RELATIONSHIP WITH THE COMPANY IS "AT-WILL" AND MAY BE TERMINATED AT ANY TIME BY EITHER ME OR THE COMPANY, WITH OR WITHOUT PRIOR NOTICE OR WARNING, AND WITH OR WITHOUT CAUSE OR REASON. I UNDERSTAND THAT NOTHING IN THE HANDBOOK SHALL LIMIT MY RIGHT OR THE COMPANY'S DISCRETIONARY RIGHT TO TERMINATE MY EMPLOYMENT. I UNDERSTAND THAT NO MANAGER, SUPERVISOR, OR EMPLOYEE OF THE COMPANY HAS ANY AUTHORITY TO ENTER INTO ANY ORAL AGREEMENT PROVIDING OTHERWISE.

I UNDERSTAND THAT THE COMPANY IS A GROWING AND CHANGING ORGANIZATION AND THAT THE COMPANY HAS THE RIGHT TO ADD TO, MODIFY OR DELETE PROVISIONS OF THE POLICIES AND PROCEDURES, AT ANY TIME WITHOUT ADVANCE NOTICE. I UNDERSTAND THAT NO ORAL STATEMENTS OR ORAL REPRESENTATIONS CAN IN ANY WAY CHANGE OR ALTER THE PROVISIONS OF THE HANDBOOK. I UNDERSTAND THAT THE INFORMATION CONTAINED IN THE HANDBOOK IS STRICTLY CONFIDENTIAL, AND I AGREE NOT TO DISCLOSE IT TO ANYONE NOT EMPLOYED BY THE COMPANY.

(3) I understand that this Handbook supersedes all other or prior employee handbooks.

Employee Printed Name

Social Security Number

Employee Signature

Date

Worksite Employer Name

CoAdvantage and your Worksite Employer are subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights law and regulations. In order to comply with these laws, CoAdvantage invites employees to voluntarily self-identify their race and ethnicity by completing this Data Record.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Again, this information has no impact on any employment decision and is to be completed only after an offer of employment has been accepted. This information will be kept confidential and is used for no purpose other than EEO reporting.

First Name: _____ Middle Initial: _____ Last Name: _____

Gender: Male Female

PLEASE CHECK THE APPLICABLE BOX BELOW:

- White
- Black or African American
- Hispanic or Latino
- American Indian/ Alaskan Native
- Asian
- Native Hawaiian or other Pacific Islander
- Two or more races

HEALTH / INJURY INFORMATION

1. Have you ever had a job-related injury?
 No (If No, go to question #2)
 Yes (If Yes, please list ALL job-related injuries below or attach a separate sheet of paper.)

Part of body affected: _____ Released to work: No Yes
 Date of injury: _____ Status of claim: Open Closed
 Job restrictions: No Yes List restrictions: _____

2. Have you ever had or been treated for any of the following conditions or diseases?

Repetitive Stress Trauma:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Back or neck problems/or injury:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Alcoholism:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Knee injury:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Drug Addiction:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Major illness in the past five years:	<input type="checkbox"/> No <input type="checkbox"/> Yes		

CRIMINAL INFORMATION

3. Have you, since the age of 18, ever been convicted of a crime? (Note: a conviction will not necessarily bar you from employment. Each conviction will be judged on its own merits with respect to time, circumstances and seriousness and relevance to job position.)

No Yes

If yes, please complete the following:

Date of conviction: _____ Type of crime: _____
 State of conviction: _____ Time served: _____
 Currently on probation or parole? No Yes
 Does Worksite Employer know of conviction? No Yes

I certify that all answers given herein are true and complete to the best of my knowledge.

Employee Printed Name

Social Security Number

Employee Signature

Date

Worksite Employer

Important Client Notice: This information is confidential and collected for limited purposes only. Once delivered to CoAdvantage, it should be either destroyed or kept in a separate and secure file with restricted access. Please consult with CoAdvantage or your legal counsel before referring to or utilizing this information.