ALPHASTAFF
Simplifying Business, Benefiting People

NEW HIRE PACKET (Second Chance)

SECTION I: TO BE COMPLETED BY EMPLOYEE (This form must be completed in its entirety to be accepted or it will be returned

Company Name: ________________________________ Original Hire Date: ______________________

Name: ____ Phone: (   ) __________ Email: __________
First MI Last

Address: ____
Street City State Zip County

Social Security #: _______-__________-__________ Sex: ❑ M ❑ F ❑Married ❑ Single Birth Date: __________

Do you work in a different state other than your above address? ❑ Yes ❑ No If Yes, list state (s)________________

I certify that I have received and understand the Company's Drug, Alcohol, and Post-Accident Drug and/or Alcohol Testing Policy ("the Policy"). I agree to comply with the Company's Policy in its entirety and understand that failure to comply is grounds for disciplinary action, up to and including termination. I consent to submit to drug and/or alcohol testing as outlined in the Company's Policy. I consent to provide specimens at the assigned collection site(s) and further consent to have urine specimens tested for drugs at a U.S. Department of Health and Human Services/Substance Abuse and Mental Health Services Administration (DHHS/SAMHSA) – certified laboratory. I consent to the release of the drug and/or alcohol test results in accordance with the Company Policy to the selected Medical Review Officer (MRO), to the Company's third-party administrator, to and within the Company on a need-to-know basis, and to additional parties in accordance with my written authorization or as otherwise required by applicable federal and/or state law. I understand that I will be given an opportunity to discuss a positive drug test result with the MRO before a result is reported to the Company as a verified positive. In the event of a post-accident drug and/or alcohol test, I understand the drug and/or alcohol test result(s) may also be provided to the workers' compensation insurance carrier. I understand that the Policy supersedes and revokes any other Company practice or Policy, at the time of distribution, relating to the use of drugs and/or alcohol in the workplace and drug and/or alcohol testing. I further understand that the Company reserves the right to interpret and administer this Policy, and at any time and at its sole discretion, amend, supplement, modify, revoke, rescind, or change this Policy, in whole or in part, with or without notice and with or without consideration. I understand that the Policy is not an express or implied contract of employment nor is it to be interpreted as such. Additionally, I understand that the Policy does not in any way affect or change the status of my at-will employment. I further understand that in this Policy is not a promise or guarantee or should be construed as a promise or guarantee that the Company will follow in any particular circumstances any particular course of action, disciplinary, rehabilitative or otherwise. My signature below acknowledges that I understand and agree that in consideration for my employment and/or continued at-will employment with the Company, I agree to the terms and requirements of the Drug, Alcohol, and Post-Accident Drug and/or Alcohol Testing Policy.

Employee's Signature:______________________________**Date:**______________________

If less than eighteen (18) years if age a parent signature is required. As the parent of the above-named minor I acknowledge the above policy and agree to the testing as described. ______________________________________
Printed Name **Signature** **Date**

COMPLETION OF THE FOLLOWING INFORMATION IS VOLUNTARY

ETHNIC CLASSIFICATION (this information is for reporting purposes only. It is not used to discriminate.)

❑ American Indian/Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ Hispanic ❑ White

MILITARY SERVICE: ❑Yes ❑No If yes: ❑Veteran ❑Vietnam Era Veteran (8/64–5/75) ❑Disabled Veteran

SECTION II: TO BE COMPLETED BY ALPHASTAFF'S CLIENT COMPANY ON SITE SUPERVISOR

Department________________ Location ____________________ Position/Title______________________

Choose one item from each line: **Rate of Pay** $______________________

❑ Hourly ❑ Salaried ❑ Piecework ❑ Commission ❑ Weekly❑ Bi-weekly ❑ Semi-monthly ❑Monthly
❑ Non-Exempt ❑ Exempt
❑ Full Time ❑ Part Time ❑ Temporary – Seasonal
❑ Bonus ❑ Yes ❑ No Frequency:____________________ ❑ Other______________________

(Circle one) EEO Code 1 2 3 4 5 6 7 8 9 (Circle or Indicate class) Benefit Class____________________

Authorized Signature______________________________________

SECTION III: TO BE COMPLETED BY THE ALPHASTAFF, INC. REPRESENTATIVE

AlphaStaff Date of Hire: ___/___/_____ W.C. Code:____________________ Employee #:____________________
Employee's First Check Date: ___/___/ ____ AlphaStaff Representative's Signature:____________________
Check if completed: New Hire (Pg 2) ❑ DD Form ❑ W-4 (withholding) ❑_______ I-9 (Card #)❑_________ Ded. Auth. ❑

ALPHASTAFF/CLIENT COMPANY/EMPLOYEE RELATIONSHIP

AlphaStaff is incorporated to provide human resource management services for your Company and employees. The following conditions exist between AlphaStaff and the employee:

- The employee is an employee of AlphaStaff and your Company, under a co-employment relationship, but is under the direct supervision of the Company.
- The employment is of mutual consent and is considered a relationship at will and does not constitute a permanent contract. AlphaStaff, the Company or the employee can terminate the employment relationship at any time.
- The employee agrees to abide by the employment policies and standards of conduct set by AlphaStaff and the Company.
- The employee understands that he/she will be in an introductory period for the first 90 days following his/her hire date with the on-site employer.
- The employee will be required to submit to drug and/or alcohol testing as part of any work-related post-accident or incident investigation. An acknowledgment and consent form will be obtained.
- The employee may be required to submit to drug/alcohol testing during the scope of his/her employment as directed by the Company. In such event, an acknowledgment and consent form will be obtained.
- The employee understands that during his/her employment he/she may be subject to a background investigation including, but not limited to, criminal or motor vehicle. In such event, a written release from the employee will be obtained to procure any background information.

EMPLOYMENT ACKNOWLEDGEMENT

- I acknowledge by my signature below that I have been informed that I will be co-employed by AlphaStaff, and my present employer now considered the Client Company of AlphaStaff.
- I understand that AlphaStaff is responsible for the payment of wages and payroll-related taxes. I also understand and agree that while I am co-employed by AlphaStaff, if AlphaStaff does not receive payment from the Company for services which I performed as an employee, AlphaStaff will still pay me the applicable minimum wage (or the legally required minimum salary or overtime pay) for any such pay period, and I agree to this method of compensation. I understand that the Client Company at all times remains obligated to pay me my regular rate of pay/salary, even if AlphaStaff is not paid by the Company.
- 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 or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact AlphaStaff 's Human Resource Department at (888) 335-9545 in order to obtain assistance in the resolution of such matters.

I certify that the answers given by me are true and correct without omissions of any kind whatsoever, and that intentional falsification of information given will be grounds for disciplinary action, up to and including termination. In addition, I certify that I have read, understand, and agree to the requirements and conditions explained in the ALPHASTAFF/COMPANY/EMPLOYEE RELATIONSHIP section, and all other information presented by the employee on this form. Further, I certify that I have been fully advised that if I am injured on the job, regardless of how minor the injury may seem, I am to report that injury *immediately* to my supervisor. I understand that any false or misleading answers to these can be sufficient reason for denial of benefits under the prevailing state Workers' Compensation Act, and basis for termination of employment. I also understand that *my answers will be researched and verified by investigation*.

Signature of Employee________________________________Please Print: __________________________Date:_______________

ACNOWLEDGMENT OF RECEIPT ANTIHARASSMENT/ANTIDISCRIMINATION POLICY & PROCEDURE

I certify that I have received a copy of my company's Antiharassment/Antidiscrimination Policy. I understand that it is my responsibility to read this policy and ask my supervisor, a member of management or to telephone AlphaStaff at (888) 335-9545 with any questions I may have about this policy. I agree to comply with the Company's policy on Antiharassment/Antidiscrimination 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 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 AlphaStaff's Human Resource Department at (888) 335-9545 in order to obtain assistance in the resolution of such matters.

Signature of Employee________________________________Please Print: __________________________ Date: _____________

ALPHASTAFF
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DIRECT DEPOSIT AUTHORIZATION FORM

PLEASE PRINT OR TYPE ALL INFORMATION FAX TO: 866-632-6419

COMPANY NAME: ______________________ **LOCATION:** ____________

EMPLOYEE NAME: ______________________ **Last 4 digits of SSN** ________

ADDRESS: ____
(Street) **(City)** **(State)** **(Zip)**

1 INSTRUCTIONS

Section 2:Please select appropriate ☐ and follow instructions listed in each other section

2 PLEASE CHECK ONE:

- ☐ New (replaces existing account)
- ☐ Change in percentage/amount **(As of date: ____________)**
- ☐ Add to existing
- ☐ Stop **(As of date: ____________)**

3 Employee Signature ____________ ***Date*** ________

I authorize my Company, AlphaStaff, and the Financial Institution indicated below, to deposit my net pay automatically to my account/ accounts, each payday. It will be my responsibility to verify that funds are in my account correctly before making withdrawals or writing checks and to notify AlphaStaff of any discrepancies and changes with my accounts in a timely manner. If funds to which I am not entitled are deposited to my account, I hereby authorize my Company and AlphaStaff to direct the Bank to return said funds. This authority will remain in effect until I have cancelled it in writing. At termination I understand that my direct deposit may be discontinued, and my final payment may be an actual check. I also understand that direct deposit takes 2-4 weeks to be fully activated, and that my financial institution needs at least 48 hours in which to credit my account .

SELECT ONE ☐ ***Checking Account*** ☐ ***Savings Account***

PLEASE ATTACH A VOIDED CHECK AND/OR A SAVINGS ACCOUNT DEPOSIT SLIP FOR VERIFICATION OF BANK DATA

*Enter %*____________ *or $*____________ *Bank Phone #:* ____________

Financial Institution____________ Branch____________

Transit/ABA #____________ Account #____________

SELECT ONE ☐ ***Checking Account*** ☐ ***Savings Account***

PLEASE ATTACH A VOIDED CHECK AND/OR A SAVINGS ACCOUNT DEPOSIT SLIP FOR VERIFICATION OF BANK DATA

*Enter %*____________ *or $*____________ *Bank Phone #:* ____________

Financial Institution____________ Branch____________

Transit/ABA #____________ Account #____________

SELECT ONE ☐ ***Checking Account*** ☐ ***Savings Account***

PLEASE ATTACH A VOIDED CHECK AND/OR A SAVINGS ACCOUNT DEPOSIT SLIP FOR VERIFICATION OF BANK DATA

*Enter %*____________ *or $*____________ *Bank Phone #:* ____________

Financial Institution____________ Branch____________

Transit/ABA #____________ Account #____________

WAGE DEDUCTION AUTHORIZATION

PLEASE PRINT AND FAX TO: 866-632-6419

PLEASE PRINT CLEARLY

COMPANY NAME: ______________________________ **LOCATION:** ______________________________

EMPLOYEE NAME: ______________________________ **DATE:** ________________ **Last 4 digits of SSN** ______

1 INSTRUCTIONS

MARK ALL APPROPRIATE ☐ ***'S Please include all documents that pertain to this Deduction.***

2 COMPANY PAYROLL CYCLE:

☐ WEEKLY	☐ BI- WEEKLY	☐ SEMI-MONTHLY	☐ OTHER

3 REQUESTED CHANGE:

In addition to any benefits that are deducted pre-tax, the following items are to be deducted post-tax unless it is marked pre-tax:

Frequency of deduction : ☐ Ongoing ☐ One Time ☐ Until Paid in full

(Must be completed by Client:)

Supervisor/Manager Signature: __________________________ Date:

	TOTAL AMOUNT		DEDUCTION PER PAYCYCLE	START DATE	END DATE
☐	$__________	Employee Loans (Total Due: _________)	$__________	__________	__________
☐	$__________	Other /Misc. ____________	$__________	__________	__________
☐	$__________	Uniforms _______________	$__________	__________	__________
☐	$__________	Medical_______________ **PRE-TAX** ☐	$__________	__________	__________
☐	$__________	Dental_______________ **PRE-TAX** ☐	$__________	__________	__________

I hereby authorize the Company to deduct the above amount(s) immediately from my pay and continue until obligation is paid in full. In the event of my separation from the Company, my signature above authorizes the Company to deduct (in full amount) any outstanding pay advance or loan previously granted to me from my final paycheck

4 REQUESTED CHANGE:

Employee Signature: ______________________________ Date: ________________

Remarks:

____

____

Form W-4 (2006)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

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 2006 expires February 16, 2007. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $850 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 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

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 line **E** below.

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.

Two earners/two 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.

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 dollar amount you are having withheld compares to your projected total tax for 2006. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

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 $1,000 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 $1,500 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):
- If your total income will be less than $55,000 ($82,000 if married), enter "2" for each eligible child.
- If your total income will be between $55,000 and $84,000 ($82,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four 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 $35,000 ($25,000 if married) see the **Two-Earner/Two-Job 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

Employee's Withholding Allowance Certificate

▶ **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.**

OMB No. 1545-0074
2006

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** ☐ Single ☐ Married ☐ 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 new card.** ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . **6** $ ______

7 I claim exemption from withholding for 2006, 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, or claim adjustments to income on your 2006 tax return.

1 Enter an estimate of your 2006 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 2006, you may have to reduce your itemized deductions if your income is over $150,500 ($75,250 if married filing separately). See *Worksheet 3* in Pub. 919 for details.) . . . **1** $

2 Enter: { $10,300 if married filing jointly or qualifying widow(er); $ 7,550 if head of household; $ 5,150 if single or married filing separately } . . . **2** $

3 **Subtract** line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . **3** $

4 Enter an estimate of your 2006 adjustments to income, including alimony, deductible IRA contributions, and student loan interest **4** $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 7* in Pub. 919) . **5** $

6 Enter an estimate of your 2006 nonwage income (such as dividends or interest) . . . **6** $

7 **Subtract** line 6 from line 5. Enter the result, but not less than "-0-" . . . **7** $

8 **Divide** the amount on line 7 by $3,300 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-Earner/Two-Job 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-Earner/Two-Job Worksheet (See *Two earners/two 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 . . . **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 2006. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2005. 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: Two-Earner/Two-Job Worksheet

Married Filing Jointly						All Others	
If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **HIGHEST** paying job are—	AND, wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $42,000	$0 - $4,500	0	$42,001 and over	32,001 - 38,000	6	$0 - $6,000	0
	4,501 - 9,000	1		38,001 - 46,000	7	6,001 - 12,000	1
	9,001 - 18,000	2		46,001 - 55,000	8	12,001 - 19,000	2
	18,001 and over	3		55,001 - 60,000	9	19,001 - 26,000	3
				60,001 - 65,000	10	26,001 - 35,000	4
$42,001 and over	$0 - $4,500	0		65,001 - 75,000	11	35,001 - 50,000	5
	4,501 - 9,000	1		75,001 - 95,000	12	50,001 - 65,000	6
	9,001 - 18,000	2		95,001 - 105,000	13	65,001 - 80,000	7
	18,001 - 22,000	3		105,001 - 120,000	14	80,001 - 90,000	8
	22,001 - 26,000	4		120,001 and over	15	90,001 - 120,000	9
	26,001 - 32,000	5				120,001 and over	10

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly		All Others	
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 - $60,000	$500	$0 - $30,000	$500
60,001 - 115,000	830	30,001 - 75,000	830
115,001 - 165,000	920	75,001 - 145,000	920
165,001 - 290,000	1,090	145,001 - 330,000	1,090
290,001 and over	1,160	330,001 and over	1,160

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, and the District of Columbia 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.

Printed on recycled paper

OMB No. 1615-0047; Expires 03/31/07

Employment Eligibility Verification

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1- Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1)** document title; **2)** issuing authority; **3)** document number, **4)** expiration date, if any; and **5)** the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, 5 minutes; **2)** completing the form, 5 minutes; and **3)** assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachuetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS

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

Employment Eligibility Verification

Please 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 eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of 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 *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

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 or national of the United States
- ☐ A Lawful Permanent Resident (Alien #) A ____________
- ☐ An alien authorized to work until ____________
  (Alien # or Admission #) ____________

Employee's Signature | Date *(month/day/year)*

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 *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

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 *(if any)*:	____________		____________		____________
Document #:	____________				
Expiration Date *(if any)*:	____________				

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 eligible 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 | Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

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

A. New Name *(if applicable)* | B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: ____________ Document #: ____________ Expiration Date (if any): ____________

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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 *(month/day/year)*

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

LISTS OF ACCEPTABLE DOCUMENTS

LIST A

Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship *(Form N-560 or N-561)*
3. Certificate of Naturalization *(Form N-550 or N-570)*
4. Unexpired foreign passport, with *I-551 stamp or* attached *Form I-94* indicating unexpired employment authorization
5. Permanent Resident Card or Alien Registration Receipt Card with photograph *(Form I-151 or I-551)*
6. Unexpired Temporary Resident Card *(Form I-688)*
7. Unexpired Employment Authorization Card *(Form I-688A)*
8. Unexpired Reentry Permit *(Form I-327)*
9. Unexpired Refugee Travel Document *(Form I-571)*
10. Unexpired Employment Authorization Document issued by DHS that contains a photograph *(Form I-688B)*

OR

LIST B

Documents that Establish Identity

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
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
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card *(Form I-197)*
6. ID Card for use of Resident Citizen in the United States *(Form I-179)*
7. Unexpired employment authorization document issued by DHS *(other than those listed under List A)*

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

ANTIHARASSMENT/ ANTIDISCRIMINATION POLICY & REPORTING PROCEDURE

It is the Company and AlphaStaff's policy that all employees should be able to enjoy a work environment free from all forms of discrimination, including harassment. As such, the Company and AlphaStaff are committed to vigorously enforcing their Antiharassment/Antidiscrimination Policy. This policy applies to all employees of the organization (without regard to position) and individuals not directly connected to the Company (e.g., an outside vendor, consultant, customer or guest).

Title VII of the Civil Rights Act of 1964, the ADEA and the ADA prohibit employment discrimination based on race, color, religion, disability, sex, age, or national origin. Harassment is considered a form of discrimination and is specifically included among the prohibitions under Title VII of the Civil Rights Act of 1964. This policy prohibits discrimination and harassment on these as well as on the basis of familial status, marital status and on any other basis that may become illegal. In addition, retaliation or reprisal taken against anyone who has expressed concern about harassment or discrimination against the individual raising the concern is illegal.

The Equal Employment Opportunity Commission (EEOC) has defined one form of harassment, sexual harassment, as "unwelcome sexual advances, requests for sexual favors, sexual comments, or other verbal or physical acts of a sexual or sex-based nature including, but not limited to drawings, pictures, jokes, and/or teasing where (1) submission to such conduct is made either explicitly or implicitly a term or a condition of an individual's employment; (2) an employment decision is based on an individual's acceptance or rejection of such conduct; or (3) such conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment."

Our Antiharassment/Antidiscrimination Policy prohibits all forms of harassment, discrimination and/or retaliation by any individual employed by, doing business with or for, or visiting the Company. Employees who believe they have been the subject of harassment, discrimination and/or retaliation or an employee who may have been a witness to harassment and/or retaliation must report the incident immediately to a manager of the Company and/or AlphaStaff (by telephoning 888-335-9545). Those who have an immediate need to know, including the alleged target of harassment or retaliation, the alleged harassers or retaliators, and any witnesses will be informed of the identity of the complainant. All individuals contacted in the course of an investigation will be advised that all persons contacted during the investigation are entitled to respect and that any retaliation or reprisal against an individual who is an alleged target of harassment or retaliation, who has made a complaint, or who has provided information in connection with a complaint, is a separate violation of the Company and AlphaStaff's policy. All information will be disclosed only on a need-to-know basis to allow the Company and AlphaStaff to investigate and resolve the incident. The Company and AlphaStaff recognize the serious nature of harassment and discrimination and will endeavor to protect; as is possible, the employee who may have been subjected to harassment or discrimination, any witnesses and the party against whom allegations have been made. Confidentiality depends on all parties agreeing not to discuss the investigation with others. The Company and AlphaStaff will take reasonable steps to repair the reputation of anyone who is falsely accused.

Harassment and discrimination are unlawful and have a negative impact on employees. Violation of the Antiharassment/Antidiscrimination Policy will not be tolerated by the Company and/or AlphaStaff and may result in discipline up to and including termination. Offensive acts or conduct have no legitimate business purpose; accordingly, any employee, regardless of his/her position within the Company, who it is determined has engaged in such conduct will be made to bear the full responsibility for such unlawful conduct.

SECOND CHANCE
DRUG, ALCOHOL AND POST-ACCIDENT DRUG AND/OR ALCOHOL TESTING POLICY

STATEMENT OF POLICY AND COVERAGE

Your work-site employer ("the Company") and AlphaStaff are committed to providing a safe, productive and healthy work environment for all employees. Individuals who abuse drugs and/or alcohol are less productive, less dependable, and are a threat to the safety, security and welfare of the Company, its employees, customers, vendors, and those who do business with the Company, as well as the general public. The establishment of a Drug, Alcohol and Post-Accident Drug and/or Alcohol Testing Policy ("Policy") is consistent with the Company's and AlphaStaff's desire to maintain a safe work environment.

The Company and AlphaStaff require you to comply with this Policy as a condition of continued employment. If you have questions regarding the Policy, you should contact a member of management at the Company and/or AlphaStaff's HR Department (available by telephoning 888-335-9545).

It is the Company and AlphaStaff's Policy that you are prohibited from the unlawful use, possession, purchase, distribution, dispensation, manufacture, sale, solicitation, or being under the influence of any narcotic, controlled substance or drug without medical authorization during working time, while you are on Company property, or while you are driving a Company vehicle. You are prohibited from the unlawful use, purchase, manufacture, sale, solicitation, or being under the influence of alcohol during working time, while you are on Company property, or while you are driving a Company vehicle. Further, you are prohibited from possessing, consuming, distributing, or dispensing alcoholic beverages while you are driving a Company vehicle, during working time or while on Company property.

METHODS OF TESTING

The Company reserves the right, within the limits of federal and applicable state laws, to question you regarding and to test you for the presence of drugs following a work-related accident as defined herein. The Company also reserves the right, within the limits of federal and applicable state laws, to question you regarding and to test you (when reasonable suspicion of use exists) for the presence of alcohol following a work-related accident as defined herein. Under the conditions of this Policy you will be asked to submit to a medical examination including urine, saliva, breath, and/or blood testing for drugs and/or alcohol.

To enforce the Company's Post-Accident Drug and/or Alcohol Testing Policy, the following types of drug screening tests will be administered to detect the presence of amphetamines, cannabinoids (marijuana), cocaine, phencyclidine (PCP), opiates and/or alcohol.

1. POST ACCIDENT

If you are involved in cause or contribute to an accident which occurs during working time, on the Company's property, or while you are driving a Company vehicle, you will be subjected to a drug and/or alcohol test. You must make yourself available for post-accident drug and/or alcohol testing. If circumstances require you to leave the scene of an accident, you must still be tested and must notify the Company immediately of your location so that testing arrangements can be made. Your failure to report any work-related accident is a violation of the Policy and is grounds for disciplinary action, up to and including termination of employment. Under certain state laws, if you have a confirmed positive test result, you may be ineligible for workers' compensation benefits.

2. REASONABLE CAUSE

You will be asked to submit to a drug and/or alcohol test if reasonable cause exists indicating that you may be under the influence of drugs and/or alcohol. "Reasonable cause" means a basis for forming a belief based on specific facts and rational inferences drawn from those facts.

3. FOLLOW UP

If you have been removed from your job due to a verified positive drug and/or alcohol test result and you return to work following treatment, you will be subject to unannounced testing to determine whether you are under the influence of drugs and/or alcohol during your working time. The frequency of unannounced drug and/or alcohol testing will be done in accordance with the recommendations of the rehabilitation counselor or Employee Assistance Program (EAP). The Company will continue the testing for an appropriate period following your return-to-work date based on guidance from the counselor or EAP.

STATE LAW

Specific provisions of the Policy that address drug and/or alcohol abuse in the workplace and state law requirements, if any, are attached as an addendum. Where a provision of the Policy and any addendum to the Policy conflict; the provisions of the addendum will prevail.

REPORTING OF TEST RESULTS

Only laboratories, which are U.S. Department of Health and Human Services/Substance Abuse and Mental Health Services Administration (DHHS/SAMHSA)-certified, will perform testing for the presence of drugs and/or alcohol. All positive drug specimens from the initial screening will then be tested a second time using a different technique and chemical principle from the initial test to insure reliability and accuracy. All test results are reported to the Medical Review Officer (MRO) for review. Confirmed positive results will only be reported to the Company after the MRO has ascertained that medically authorized prescriptions or other legal substances do not account for your initial positive test.

CHALLENGES TO CONFIRMED POSITIVE TEST RESULTS

You have five (5) working days (after receiving notice from the Company of a confirmed positive test result) to submit information to the Company explaining or contesting test results.

If the Company deems your explanation or challenge of a positive test result to be unsatisfactory, the Company will provide you with an explanation as to why your explanation is deemed unsatisfactory, along with the report of the positive result(s). This explanation will be provided to you within fifteen (15) days of receipt of your explanation or challenge.

You may undertake an administrative challenge of the test result by filing a claim for benefits in the appropriate state compensation claim forum. If no workplace injury has occurred, you must challenge the test result in a court of competent jurisdiction. If you undertake a challenge to the results of a test, it is your responsibility to notify the testing laboratory of the challenge. The laboratory will retain your testing sample until your case is resolved.

In the event of a positive test result, you may request independent testing (at your expense) of a portion of the tested specimen for verification of the test result. The independent testing must be performed during the one hundred eighty (180) day period following the written notification of your positive test result. The laboratory

performing this testing must be licensed or certified. The result(s) of the independent testing may be used in any administrative or legal proceeding challenging your test results challenge.

INSPECTIONS

The Company reserves the right to conduct inspections of vehicles, premises, property (including but not limited to offices, desks, lockers, computers, etc.) and personal effects (such as lunch boxes/bags, purses, gym bags, backpacks, briefcases, packages, and coats) where there is reasonable cause to believe that the Policy has been violated. Any expectation of privacy you may have will be eliminated as a result of the Company's reasonable cause to believe the Policy has been violated. As such, you do not have the right to interfere with or object to such inspections. Where reasonably practical, inspections will be conducted in your presence if you have been implicated in the potential Policy violation.

POLICY PROHIBITIONS

You are prohibited from the following conduct during working time, while on Company property, or while operating a Company vehicle:

a) Being under the influence of narcotics, drugs and/or controlled substances without medical authorization (as defined by cut-off levels established in the "Mandatory Guidelines for Federal Workplace Drug Testing Programs") and/or alcohol (as defined herein).
b) Abusing prescription drugs; which includes exceeding the recommended prescribed dosage or using another individual's prescribed medication(s).
   In addition, if you are employed in a safety-sensitive position, while you are at work you are prohibited from using and/or from being under the influence of prescribed and or over-the-counter medication(s) which have the potential to alter or to adversely affect your judgment, motor skills, to induce sleepiness or to otherwise detract from your safe job performance.
c) Failing to notify a supervisor prior to reporting to work if you believe that you are under the influence of narcotics, drugs, controlled substances and/or alcohol.
d) Switching, tampering with or adulterating any specimen or sample collected under the Policy or attempting to do so.
e) Refusing to cooperate with the terms of the Policy; which includes: submitting to questioning, drug testing, medical or physical tests or examinations, when requested or conducted by the Company or its designee. A refusal to test includes but is not limited to conduct which obstructs testing such as failure to sign necessary paperwork, failure to report to the collection/testing site at the appointed time, and failure to be reasonably available for post-accident drug and/or alcohol testing.
f) Failing to consent to participate in and abide by the terms and recommendations of any Employee Assistance Program (EAP) or rehabilitation program if within the consequences of the Policy. Failure to participate in and abide by the rehabilitation program includes but is not limited to failure to follow recommendations, if any, regarding behavior modification and abstinence, and failure to be available for any prescribed continuing or follow-up sessions or testing.

You are encouraged to report any use of a prescription or over-the counter drug, which may alter your ability to perform the essential functions of your position to a member of management at the Company and/or AlphaStaff's HR Department. The Company and/or AlphaStaff's HR Department will determine what, if any, accommodation(s) can be made.

CONSEQUENCES FOR POLICY VIOLATIONS

If you engage in any of the prohibited conducts, you are in violation of the Policy and will be subject to discipline up to and including termination as follows:

a) During your first ninety (90) days of employment, a confirmed positive drug and/or alcohol test will result in your termination of employment.

b) If you have completed ninety (90) days of employment with the Company, you will be referred to a treatment program if the following criteria are met:

   1) It is your first and only Policy violation.
   2) You have not engaged in the sale of drugs or any other criminal activity, including but not limited to theft.

c) The Company reserves the right to reassign you to another position at a rate of pay commensurate with the reassigned position. Such work, which in the sole judgment of management, will not by virtue of your confirmed drug and/or alcohol abuse, endanger the safety of your coworkers, the general public or pose an unreasonable risk to the Company.

d) You must agree to participate in a rehabilitation program. The Company reserves the right to require you to enter into and abide by one or more of the following: a Rehabilitation Agreement and/or a Return-to-Work Agreement. When you return to work following treatment, you will be subject to unannounced testing to determine whether you are under the influence of drugs and/or alcohol during your working time. The frequency of unannounced drug and/or alcohol testing will be done in accordance with the recommendations of the rehabilitation counselor or Employee Assistance Program (EAP). The Company will continue the testing for an appropriate period (12 months) following your return-to-work date based on guidance from the counselor or EAP.

e) If you are in safety-sensitive position and are required to participate in a post-accident drug and/or alcohol testing, you will be removed from your position and will be placed on administrative leave or in a non-safety sensitive position until the Company receives the test results.

f) If you are injured in a work-related accident, in addition to the above consequences, you may also forfeit your eligibility for Workers' Compensation benefits.

g) If you refuse to submit to post-accident drug and/or alcohol testing, your employment will be terminated and your Workers' Compensation benefits may be denied.

h) If it is determined you have provided an adulterated urine sample (one that is proven to have had substances added to it to mask potential drugs in the system) or one that has been switched or tampered with, your employment with the Company will be terminated.

i) If your employment with the Company is terminated as a result of your violating the Company's Drug and Alcohol and Post-Accident Drug and/or Alcohol Testing Policy, you may be denied unemployment benefits.

In no case will the Company continue to employ you if you have two (2) occurrences during your employment. An "occurrence" is defined as a confirmed positive drug test result or a confirmed alcohol test of a level of 0.05 or greater.

While the discipline imposed will depend on the circumstances, and the Company reserves the right to determine, in its sole discretion, the discipline imposed, ordinarily certain offenses will result in your immediate termination, including but not limited to the possession, sale or use of illegal drugs on the Company's premises, during working time, or while driving a Company vehicle.

EMPLOYEE ASSISTANCE PROGRAM

The Company provides you and your family members with an Employee Assistance Program (EAP) benefit. The EAP provides confidential assessment, referral, and short-term counseling on a wide range of issues,

including drug and/or alcohol abuse, for individuals twenty-four (24) hours a day/seven (7) days a week. The EAP can be contacted at the telephone number provided on the brochure.

Your participation in the EAP is voluntary and completely confidential. Your request for assistance or participation in the EAP will not allow you to avoid discipline if you have violated the Company's Drug, Alcohol and Post-Accident Drug and/or Alcohol Testing Policy and rules of conduct. Information provided when utilizing EAP services will be kept confidential in accordance with any applicable federal and/or state law requirements.

Expenses you incur as a result of substance abuse treatment may be covered by the Company's medical insurance plan (if any). However, any costs not covered by the insurance plan which are not otherwise required to be paid by any applicable plan are entirely your sole financial responsibility.

CONFIDENTIALITY AND PRIVACY

All drug and/or alcohol test results are reported to the Company and are confidential. The release of drug and/or alcohol test results and other information gained in the testing process will only be disclosed within the Company on a need-to-know basis, in accordance with your written authorization, and/or as required by applicable law.

The Company will attempt to ensure that all aspects of the testing process including specimen or sample collection are as private and confidential as is reasonably practical. You will not be observed while providing a urine specimen unless there is reasonable cause to believe you have tampered with, adulterated, switched, or attempted to tamper with, adulterate or switch a urine specimen. You may be asked, under certain circumstances, to provide additional specimens.

EMPLOYEE ACKNOWLEDGEMENT

You will be required to sign an Acknowledgement of Receipt of Policy and Consent to Testing form. Your signature on this document acknowledges your understanding of and agreement to comply with the Company's Drug, Alcohol and Post-Accident Drug and/or Alcohol Testing Policy.

RESERVATION OF RIGHTS

This Policy supersedes and revokes any other Company practice or Policy, at the time of distribution, relating to the use of drugs and/or alcohol in the workplace and drug and/or alcohol testing. The Company reserves the right to interpret and administer this Policy, and at any time and at its sole discretion, amend, supplement, modify, revoke, rescind, or change this Policy, in whole or in part, with or without notice and with or without consideration.

This Policy is not an express or implied contract of employment nor is it to be interpreted as such. Additionally, this Policy does not in any way affect or change the status of any at-will employee. Nothing in this Policy is a promise or guarantee or should be construed as a promise or guarantee that the Company will follow in any particular circumstances any particular course of action, disciplinary, rehabilitative or otherwise.

DEFINITIONS

Accident means an incident that the employee causes, contributes to, or is involved in that involves: 1) a fatality; 2) personal injury to the employee or others requiring off-site medical attention and/or lost work time; and/or 3) damage to Company property exceeding $1,000.00.

Company Premises means all buildings, facilities, property (including parking lots) used by the Company to conduct its business including all work sites to which employees are assigned in the course of the performance of their duties for the Company.

Drug means a controlled substance, as defined in Schedules I through V of Section 202 of the Controlled Substances Act, 21 U.S.C.§ 812, including cocaine, opiates, marijuana, amphetamines, phencyclidine (PCP), barbiturates, benzodiazepines, propoxyphene, methodone and methaqualone. The term “illegal drug” does not include the use of a drug obtained and taken under supervision by and in accordance with prescriptions or other instructions issued by a licensed health care professional and other drugs otherwise authorized to be used under the Controlled Substances Act.

During Working Time or Work Time means time during which the employee is being paid to work for or represent the Company or the employee is representing the Company’s interests. The term includes all paid break and meal times and any Company sponsored events.

Employee means any full-time, part-time, and subcontracted individual employed by the Company.

Laboratory means a facility certified by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA assures the highest level of laboratory accuracy and reliability. SAMHSA certified laboratories are inspected regularly and are required to demonstrate proficiency in testing blind (unknown) samples.

Medical Review Officer means a licensed physician who is knowledgeable in drug abuse and chemical dependency disorders, pharmacology and toxicology, and the pertinent rules, regulations, and laws that apply to workplace drug testing. The MRO reviews all laboratory reports and related paperwork for each test result. The MRO interviews the donors of all positive tests to determine if a legitimate medical explanation for the positive test exists. The MRO reports test results to the Company.

Safety-sensitive Position means occupations and/or job assignments, as designated by the Company, in which an employee’s inability to safely function in his/her job could place the safety of the individual, others, and/or the interests of the Company at risk.

Under the Influence of Alcohol means the presence of alcohol in the individual’s system, which equals or exceeds a blood alcohol content (“BAC”) of 0.05.