Mid Oregon PERSONNEL

Employee Name:		**Phone:**	
Social Security:		**Start Date:**	
Company:		**Wage:**	
Position:		**DOB:**	
Address:		**Email:**	

New Employee Check List			
IN FILE DOCUMENTS		**TASKS**	
Copies of ID		Processed Date	
W-4's		Add Talent to Bold	
New Hire Cover Sheet		Process E-Verify	
Any paper onboarding documents		Upload Background Auth to Bold (if applicable)	
		Complete Background Check (if applicable)	
		Complete Drug Test (if applicable)	
		File I9	
		OR Reporting	
		Added to Payroll Cover Sheet	
		Added to Payroll Book	
		W-4's in Bold	
		Direct Deposit Auth in Bold	
		8850 in Bold	
		References Checked	
		New Hire Pay Statement (copy to talent/copy in Bold)	
		New Hire Cover Sheet to Payroll	
		Upload remaining new hire documents if paper	

ACTIVITY LOG

Date	Activity/Comments

2026 Form OR-W-4

Oregon Department of Revenue

19612601010000

Office use only

Oregon Withholding Statement and Exemption Certificate

First name	Initial	Last name	Social Security number (SSN)	☐ Redetermination
			– –	

Address	City	State	ZIP code

Note: Your eligibility to claim a certain number of allowances or an exemption from withholding may be subject to review by the Oregon Department of Revenue. Your employer may be required to send a copy of this form to the department for review.

1. **Select one:** ☐ Single ☐ Married ☐ Married, but withhold at the higher single rate.
   Note: Select "Single" if you're married but legally separated or your spouse is a non-U.S. citizen without permanent resident status.

2. **Allowances.** Enter the number from Worksheet A, line **A5,** Worksheet B, line **B9,** or Worksheet C, line **C6** (see instructions). Otherwise, if you aren't exempt, **enter 0** ..... 2.

3. **Additional amount** from Worksheet C, line **C10,** or other amount to withhold from each paycheck ... 3. .00

4. **Exemption from withholding.** I certify my wages are exempt from withholding and I meet the conditions for exemption as stated in Form OR-W-4 Instructions. Complete **both** lines:
   • Enter your exemption code from the Exemption chart in Form OR-W-4 Instructions ..... 4a.
   • Write "Exempt" ..... 4b.

Sign here. Under penalty of false swearing, I declare the information provided is true, correct, and complete.

Employee signature (This form isn't valid unless signed.)	Date

Employer use only.

Employer name	Federal employer identification number (FEIN)		
Mid Oregon Personnel	93-0903486		
Employer address	**City**	**State**	**ZIP code**
187 NW Second Street	Prineville	OR	97754

—Submit your completed form to your employer—

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

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

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

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

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

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Mid Oregon Personnel 187 NW Second Street Prineville, OR 97754		93-0903486

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Mid Oregon Personnel	**187 NW Second Street Prineville, OR 97754**

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Company Assigned To:_____ Pay Period:_____

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS (ACH CREDITS)

Company Name: Mid Oregon Personnel Services, Inc Company ID Number: 93-0903486

I (we) hereby authorize Mid Oregon Personnel Services, Inc., hereafter called COMPANY, to initiate all credit entries (and appropriate debit and adjustment entries) to my (our) ___ Checking Account__ Savings Account (select one) indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provision of U.S. law.

Depository (Bank) Name:_____

City: _____ State: _____ Zip:_____

Routing Number: _____ Account Number _____

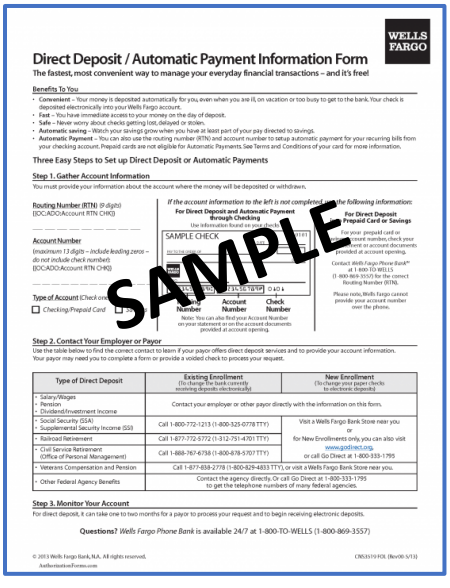
This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s): _____ ID Number (if applicable): _____
(Please Print)

Date: _____ Signature:_____

NOTE: WRITTEN CREDIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

Please attach a voided check OR a letter from your bank that shows your account and routing number.
WE WILL NOT BE ABLE TO ESTABLISH DIRECT DEPOSIT WITHOUT A VOIDED CHECK OR DIRECT DEPOSIT LETTER



BACKGROUND AUTHORIZATION FORM - YARDSTIK

MID OREGON PERSONNEL

Please supply the following information to facilitate a background check on you.

Full Name (First, Middle, Last): _____

Alias Name(s) Used Within the Last 7 Years: _____

Social Security Number: _____ Date of Birth: _____

Driver License #.: _____ State Issued: _____ Expiration Date: _____

Email Address: _____

Full Current Address	City	State	Zip Code
Additional Previous Address Within the Last 7 Years	City	State	Zip Code
Additional Previous Address Within the Last 7 Years	City	State	Zip Code
Additional Previous Address Within the Last 7 Years	City	State	Zip Code

By signing below you hereby authorize the obtaining of consumer reports by the Company any time after receipt of this authorization and throughout the course of your employment. You understand that the scope of your authorization is not limited to the present and, if you are hired, will continue throughout the course of your employment and allow the Company to conduct future screenings for retention, promotion or reassignment, as permitted by law and unless revoked by you in writing.

To this end, you authorize any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information about you requested by Yardstik, Inc. 100 Washington Ave S #600, Minneapolis, MN 55401 and/or the Company.

Applicant Signature: _____ **Date:** _____

For Office Use Only:

☐ STANDARD BACKGROUND ☐ OTHER: _____ BILL TO:_____

BACKGROUND CHECK DISCLOSURE

Pursuant to the Federal Fair Credit Reporting Act ("FCRA") and its applicable state counterparts, Mid Oregon Personnel ("the Company") may obtain consumer reports or investigative consumer reports on you for employment purposes in connection with your employment, potential employment, contract for services, volunteer position or other employment-related purpose. The Company may procure consumer reports on you both in connection with your application, and, if applicable, at any time during your employment, contract for services or volunteer position with the Company. Consumer reports are written, oral or other communications that bear on your creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that are used (or expected to be used) as a factor in establishing eligibility for employment purposes. "Investigative consumer reports" are consumer reports (or portions of consumer reports) in which information is obtained through personal interviews with your neighbors, friends, associates or acquaintances, and are commonly obtained in connection with education or employment reference checks.

Consumer reports may include items such as employment verifications, education verifications, credit history, driving records, criminal history, motor vehicle records, licensures, certifications, social security number verification, drug testing results or other information obtained through background check services. The information may be obtained from private and public record sources, including personal interviews with your neighbors, friends, associates, or acquaintances.

You may find a "A Summary of Your Rights under the Fair Credit Report Act" at:
http ://www.consu mer.ftc.gov/articles/pdf-0096-fair-credit-reporting-act.pdf

The name of the consumer reporting agency from whom the Company may procure consumer reports or investigative consumer reports is Yardstik, 100 Washington Ave S #600, Minneapolis, MN 55401, 888-278-5042. Please direct all inquiries to Yardstik.

You have the right to dispute incomplete or inaccurate information in your consumer report. You have the right, for a reasonable time after receipt of this notice, to make a written request to Yardstik for a complete and accurate disclosure of the nature and scope of the investigation requested by the Company, as well as to receive a written summary of your rights and remedies under the law.

You may find information about Yardstik's privacy practices, including whether your personal information will be sent to third parties outside the United States or its territories, as well as information concerning contact information for Yardstik's representatives who can assist you with additional information regarding Yardstik's privacy practices in the event of a compromise of your information, on Yardstik's website, www.yardstik.com.

Please sign below to acknowledge your receipt of this Background Check Disclosure.

Signature: _____ **Date:** _____

Printed Name: _____

Mid Oregon Personnel Services, Inc. Sick Leave Policy
---------- For Temporary and Leased Employees Only ----------

This Sick Leave Policy is adopted by Mid Oregon Personnel Services, Inc. (the "Company") starting January 1, 2016. Sick leave provided pursuant to this policy is exclusively for the Company's temporary and leased employees; no other employees shall be eligible to receive sick leave pursuant to this policy. Temporary and leased employees are not entitled to receive any sick leave or other paid time off except as provided in this policy.

Under this sick leave policy, an employee accrues sick leave that the employee may use for any purpose allowed under Oregon's Sick Leave Law ("OSL"). Those purposes include, for example, leave for: an employee's own mental or physical illness, injury, or health condition, or that of certain family members; any purpose covered by the Oregon Family Leave Act (which include leave for the birth of the Employee's child or placement of a child for adoption or foster care; to care for a family member with a serious health condition or the employee's own health condition; for pregnancy disability or prenatal care; to care for a sick child; and for bereavement leave); domestic violence, stalking, harassment or sexual assault; preventive health and dental care; or public health emergencies.

Sick leave will begin accruing from the employee's date of hire and may not be used prior to accrual. Additionally, no employee may use accrued sick leave until after the employee has completed 90 calendar days of employment with the Company.

Accrual rate: Each eligible employee accrues 1 hour of sick leave for every 30 hours that the employee works, up to a maximum accrual of 40 hours in each year of employment. Once an employee has accrued 40 hours of sick leave in a year of employment, the employee shall cease to accrue additional sick leave until the next anniversary of the employee's employment with the Company, at which time the employee shall once again begin accruing sick leave.

Carry over: An employee who has accrued but unused sick leave at the end of each year of employment with the Company may carry over into the following year up to 40 hours of accrued but unused sick leave. Any accrued but unused sick leave in excess of 40 hours automatically lapses at the end of each year of employment and may not be used by the employee thereafter.

Annual usage cap: An employee may not use more than 40 hours of sick leave in any year.

Requesting sick leave: Employees must submit their sick leave request as soon as practicable and, except in the case of an unforeseeable need for such leave, no later than ten days in advance of the date on which the leave is to begin. For foreseeable uses of sick time, employees must make a reasonable attempt to schedule their use of sick time in a manner that does not unduly disrupt the Company's operations. Requests for sick leave where the employee has accrued sick leave remaining, and where the request is covered by OSL, however, shall not be denied.

The Company understands that, from time to time, situations arise in which meeting the requirements for advance notice is not possible and will make exceptions as needed and as the Company is able to do so. Consistent or other failure to meet these notice requirements, however, may lead to disciplinary action with respect to the employee.

Termination of Employment: On termination of an employee's employment the Company, the employee's accrued but unused sick leave time will automatically lapse and the value of that accrued but unused sick leave time will not be paid to the employee. However, if an employee becomes reemployed with the Company within 180 days of the date of termination of the employee's employment, then, on reemployment, the employee shall automatically be granted any accrued but unused sick leave time that the employee had as of termination.

No Retaliation or Discrimination: The Company strictly prohibits retaliation toward any employee for inquiring about the employee's entitlement to leave that is covered by the OSL, submitting a request for such leave, taking leave pursuant to OSL to which the employee is entitled, participating in an investigation, proceeding, or hearing relating to OSL, or invoking, in good faith, any provision of the OSL law. Employees who believe they have witnessed or experienced any such retaliation or discrimination should contact the owners of the Company.

Print: X_____

Sign: X_____ Date: _____

*This is your copy to keep. No signature required.

Workplace Accommodations Notice

Mid Oregon Personnel is an equal opportunity employer and does not discriminate on the basis of race, religion, color, sex, age, national origin, disability, veteran status, sexual orientation, gender identity, gender expression or any other classification protected by law.

Mid Oregon Personnel will make reasonable accommodations for known physical or mental disabilities of an applicant or employee as well as known limitations related to pregnancy, childbirth or a related medical condition, such as lactation, unless the accommodation would cause an undue hardship. Among other possibilities, reasonable accommodations could include:

- Acquisition or modification of equipment or devices;
- More frequent or longer break periods or periodic rest;
- Assistance with manual labor; or
- Modification of work schedules or job assignments.

Employees and job applicants have a right to be free from unlawful discrimination and retaliation

For this reason, Mid Oregon Personnel will not: • Deny employment opportunities on the

basis of a need for reasonable accommodation
- Deny reasonable accommodation for known limitations, unless the accommodation would cause an undue hardship.
- Take an adverse employment action, discriminate or retaliate because the applicant or employee has inquired about, requested or used a reasonable accommodation.
- Require an applicant or an employee to accept an accommodation that is unnecessary.
- Require an employee to take family leave or any other leave, if the employer can make reasonable accommodation instead.

To request an accommodation or to discuss concerns or questions about this notice, please contact any one of our supervisors or call at 541-447-1299 for the human resources department.

Mid Oregon PERSONNEL
GROUP OF COMPANIES

At Mid Oregon Personnel, we believe that accidents are caused- they don't just happen. Therefore to avoid the cause, one must first identify the cause.

Please list six ways that people can or have been injured in places where you have worked:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list six ways to effectively accomplish your job requirements while avoiding the injury exposures you have listed above:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____
6. _____
   _____

Mid Oregon PERSONNEL
GROUP OF COMPANIES

Influencing Attitudes for Safety

Do Attitudes Matter?

Attitudes have a great deal to so with how staff members perform their daily tasks. Some types of attitudes are conducive to safety and some types lead toward accidents and injury.

Attitudes- The Bad Ones:

- Safety is a matter of chance- I will get hurt when my number comes up.
- It is necessary to take chances to get my job done.
- If I know what I'm doing, I can take risks and get away with it.
- This organization does not really care about safety.
- My coworkers will not respect me if I am always being careful.

Attitudes- The Good Ones:

- Accidents have causes- they can be prevented.
- Accidents interfere with production- safe work is efficient work.
- The organization is truly interested in safety and so are the people who work here.
- My c o workers will respect me if I show good judgment and work safely.
- Working safely is a mark of skill. We are proud of our safety record.

There are many other attitudes for safety. If we accept and express positive attitudes for safety those around us will do the same and safety will become a part of our daily conversation.

Create a Culture of Safety:

Attitudes grow and, like anything that grows, they flourish best in favorable environments. If we create a good environment for safety and working for safety, everyone will be influenced by what they see.

New Staff are strongly influenced by the behavior of the veteran workers and supervisors. Be sure they are given the correct direction right from the start.

Attitudes for safety will grow if people take part in discussions about how accidents can be prevented.

RULES OF CONDUCT

MID OREGON PERSONNEL SERVICES, INC. (PSI)

Most employees do not need a list of rules or regulations to guide their personal conduct. Normally, employees respect the person and safety of other people, and follow directives from proper authority. The following list is not intended to describe all situations where discipline may be necessary. It does represent important rules and policies that, if violated, will result in immediate disciplinary action up to and including termination of employment.

A. Failure to report for work without notifying our office and the supervisor you are assigned to.
B. Leaving work before quitting time without notifying and getting permission from your supervisor.
C. Admission of consumption, bringing to, or consuming intoxicants on the job site, or reporting for duty with detectable amounts of intoxicants in your system.
D. Non-conformance with posted fire protection programs including smoking outside designated areas.
E. Removal of property from job site without written permission.
F. Theft or destruction of property belonging to or in charge of another employee.
G. Sleeping on duty.
H. Violation of safe work rules.
I. Intimidation and or/molestation of any individual or group of employees.
J. Neglect of duty or loafing on the job.
K. Gross misconduct including horseplay, fighting or throwing anything.
L. Destruction or defacing property due to a willful or careless act.
M. Failure to conform to prescribed procedures.
N. Unauthorized use or operation of equipment.
O. Willful falsification of company records.
P. Bringing unauthorized people to your work site.

The quality of work you do is your signature. Do your work to the best of your ability. Impress someone with your eagerness and hustle. Win yourself a full-time job.

Do not lose sight of the fact you are working for PSI. Should you have any questions or complaints regarding job assignments, wage rates, etc., contact our office and we will answer them. DO NOT take complaints to the company where you are assigned.

Should you be let go from your assigned work site, you are responsible for notifying our office as to your status. DO NOT depend upon someone else to notify us that your assignment has ended. Someone will answer our phone 7 days a week, 24 hours a day.

PSI covers you for Worker's Compensation. Should you be injured at your job site, it is imperative we are contacted prior to seeking medical attention unless it is a medical emergency. Failure to do so could result in your termination.

We are proud of all those who work at PSI and hope that you will enjoy working with us. We have found that close cooperation, mutual respect, and courtesy, are key items that make our company a good place to work. We invite your best efforts to help us achieve our goals and we sincerely appreciate your cooperation and loyalty.

I RECOGNIZE THAT IF I AM HIRED BY PSI, IT IS FOR THE SOLE AND EXCLUSIVE PURPOSE OF BEING PLACED FOR WORK IN ONE OF OUR CLIENT MILLS OR BUSINESSES.

"I HAVE BEEN ADVISED BY PSI AND UNDERSTAND THAT I AM AND WILL AT ALL TIMES DURING MY EMPLOYMENT HEREUNDER, BE COVERED BY WORKER'S COMPENSATION INSURANCE. I UNDERSTAND THAT ANY INJURY I RECEIVE WHILE IN THE EMPLOY OF PSI, AND ANY OF THE CLIENT MILLS OR BUSINESSES, WILL BE COVERED SOLELY AND EXCLUSIVELY BY WORKER'S COMPENSATION INSURANCE, AND IN CONSIDERATION OF THAT FACT AND OF THE JOB WHICH I AM GIVEN HEREWITH, I DO HEREBY ACKNOWLEDGE AND AGREE THAT I DO NOT HAVE NOR WILL I MAKE ANY CLAIM OR BRING ANY ACTION OR SUIT AGAINST PSI AND/OR ANY OF THE CLIENT MILLS OR BUSINESSES FOR PERSONAL INJURIES I MAY RECEIVE AS A RESULT OF WORKING THEREIN, EXCEPT A CLAIM FOR WORKER'S COMPENSATION BENEFITS."

DATE_____ **SIGNATURE** _____

Since the information, policies, and benefits described in the PSI handbook are subject to change, I acknowledge that revisions to the handbook may occur, and all such revisions will apply to my employment. All changes will be communicated through official written notices, and I understand that revised information may modify or eliminate existing policies described in this handbook if particular circumstances require it. Only PSI may adopt revisions to the policies in this handbook.

I have entered into my employment relationship with PSI voluntarily and acknowledge that there is no employment contract or guarantee of a specified length of employment. Accordingly, either PSI or I can terminate the relationship at will, with or without cause, at any time. Furthermore, nothing in the handbook or in any other communication, either written or oral, made at the time of hire or during the course of employment by a representative of PSI shall create or is intended in any way to create a contract of employment either expressed or implied. Only the president of PSI has the authority to enter into an agreement with anyone for any reason other than one for At-Will employment. Any such agreement must be in writing and signed by the president.

I have received, read, and understand the Employee Handbook. I further understand that it is my responsibility to comply with the policies contained in this handbook and any revision made to it.

DATE_____ **SIGNATURE**_____

As the potential for serious injury or death is present in many aspects of the jobs we provide, it is imperative that employees be free of substances of abuse during working hours. For this reason applicants for employment with PSI are required to submit to a Urine Screen for substances of abuse as a condition of employment.

The Company reserves the right, at its sole discretion, to test employees on a random, periodic, or blanket testing basis. At its sole discretion, PSI may test employees who provide reasonable suspicion that the employee is impaired by drugs or intoxicants. A drug test requested or administered by a client company or its agent, or an admission of consumption of drugs or intoxicating substances to a client company or its agent, will be considered as a drug test requested or administered by PSI or its agent, or as an admission of consumption of drugs or intoxicating substances to PSI or its agent. If an employee feels his/her results are inaccurate, at his/her own expense the employee may be retested immediately.

The results will be reported only to individuals designated by the company, and will be held in the strictest of confidence by all personnel who have access to the information. This information may be shared between the client representative and a PSI representative. The information gained from the testing will be used in the overall evaluation of the fitness of the applicant for the position for which they are applying.

If an employee tests positive (Opiates 300+ ng/ml, Amphet/Metham 300+ ng/ml, Phencyclidine 25+ ng/ml, Cocaine 300+ ng/ml, Cannabinoids 15+ ng/ml, Barbiturate 200+ ng/ml, alcohol any), or fails to pass a test for substances of abuse, or admits to consuming substances of abuse, he will be subject to immediate discharge. In the event of discharge the individual may apply for employment after 90 days.

Possession, use of alcohol or illicit substances, or possession of drug paraphernalia on any work site, client premises, or in client vehicles is strictly prohibited. Violation of this rule will result in dismissal of the employee from the contractor's work-site and will subject the employee to discipline up to and including discharge.

When appropriate PSI may, at its sole discretion, grant a leave of absence for the purpose of treatment and rehabilitation to an employee who makes his alcohol or drug addiction known to the company.

I have read and understand the PERSONNEL POLICY which outlines and explains the procedures and terms of the URINE SCREEN FOR SUBSTANCES OF ABUSE and agree to abide by the policy.

DATE_____ SIGNATURE_____

I hereby authorize PSI and the licensed laboratory selected by PSI to perform a Urinalysis on a urine specimen provided by me to test for drug use. I also give my permission to this laboratory to release the results of this drug test(s) to PSI or its agents. I understand that PSI will treat the information confidentially and may in its sole judgment utilize the report on the results of this drug test(s) to determine my suitability for employment. Additionally, I understand and agree that if the test results indicate apparent drug use, PSI may reject my application for employment, and that if I am employed, my employment may be promptly terminated.

DATE _____ **SIGNATURE** _____

These company policy statements are provided as standards and guidelines for the employer and the employee but are not considered as an employment contract between the parties. It is recognized that both the employer and the employee have reserved the right to terminate the employment relationship. Additionally, the employer reserves the right to delete, modify or expand the company policies in and beyond those expressed.

I have read the above policy statements through completely. I understand all the rules and regulations stated therein and agree to abide by the rules and the spirit of employment while employed by PSI.

DATE_____ SIGNATURE _____

I understand that PSI may provide their clients with copies of my personnel file and other information surrounding my employment history at PSI.

DATE_____ SIGNATURE _____

Mid Oregon PERSONNEL
GROUP OF COMPANIES

The Culture of MidOregon Personnel

At Mid Oregon Personnel, we care about the safety, health and well being of our employees. We value the contributions our employees make toward our success. We support the communities in which we operate, and we value honesty, integrity, and teamwork.

We Value Our Employees

Our business operates with a goal of zero damage to people, property and product. It is our policy to provide safe working conditions. At Mid Oregon Personnel, everyone shares equally in the responsibility of identifying hazards, following safety rules and operating practices. All jobs and tasks must be performed in a safe manner, as safety is crucial to the quality of our services.

Safety Policy

At Mid Oregon Personnel, no phase of the operation is considered more important than accident prevention. It is our policy to provide and maintain safe working conditions and to follow operating practices that will safeguard all employees. No job will be considered properly completed unless it is performed in a safe manner.

Mid Oregon Personnel is concerned about the health and good work habits of its employees. In the event you are injured or unable to perform your job, we want to help you obtain the best treatment, so you can return to your regular job as soon as possible.

Zero Tolerance, Substance of Abuse Free Workplace

The company has a vital interest in maintaining a safe, healthy and efficient workplace for the benefit of its employees, clients and the public. The use of performance impairing drugs can cause avoidable injuries to employees, damage to property and productivity losses. In our efforts to provide a safe workplace, we have a substance abuse policy. Reporting to work under the influence of any intoxicant, legal or otherwise, is prohibited. The use, possession, transfer or sale of illegal substances, alcohol, or any other substances which impair job performance or pose a hazard to the safety and welfare of the employee, the public, or other employees is strictly prohibited and may result in immediate disciplinary action up to and including termination.

Return to Work

If an employee is injured on the job, our goal is to assist in obtaining medical treatment and return the employee to work as soon as possible. Our employees also have responsibilities for notifying us of their condition and providing appropriate information to assist in the Return to Work process. Through this joint effort, recoveries are faster and employees return to productive work environments sooner.

I have read Mid Oregon Personnel's Company Culture statement and understand the commitment to the safety and health of employees and customers/clients.

_____ _____

Print name Signature Date

Safety Orientation Checklist for New Employees

Safety Mission Statement

Mid Oregon Personnel Services has a strong commitment to ensuring the personal safety of all of its employees. At Mid Oregon Personnel we believe safety begins with you, the individual employee. If you assume primary responsibility for your own safety, you will not be injured. This attitude is pivotal to the success of any safety program in any company to which you are assigned.

_____Injury Reporting Policy:
Worker has been told to notify his/her supervisor immediately after receiving any injury that breaks the skin or causes serious pain. Injuries causing less pain are still to be reported if the pain is still present at the start of the next shift. In both cases the worker will contact Mid Oregon Personnel as well. Employee agrees to notify Mid Oregon Personnel before seeking medical attention for any work related injury unless it is a medical emergency.

_____ Failure to notify Mid Oregon Personnel before seeking medical attention for any work related injury, unless it is a medical emergency, will result in termination.

_____General Safety Rules:
Worker has received, read, understands, and agrees to follow the policies of the Rules of Conduct and company Handbook including the general safety rules.

____Energy Control (Lockout/Tagout):
No employee is authorized to work on any equipment without specific training about that piece of equipment. This training must include instruction about de-energizing the machine and isolating it from its power source.

____Chemical Hazards:
The Host employer will have a list of any hazardous chemicals. There will be a Safety Data Sheet (SDS) for each chemical. The SDS identifies the chemical, the specific hazard, and what to do if exposed to the chemical. Worker must ask about such chemicals and get instruction about how to read those specific sheets.

Various Hazards: ____**Hearing Conservation**. Basically if you have to raise your voice to communicate, you need hearing protection. Ask your supervisor. ____**Fall Protection**. If your feet are more than four feet off the ground, you need fall protection. This protection will generally be job specific. Ask your supervisor. ____**Personal Protective Equipment**. This will vary from job to job. Ask your supervisor what is required. ____**Generic Hazards**. Think in terms of what job you are sending the employee to. E.g. in a mill, rings, bracelets, long hair and baggy clothes are dangerous. Is there need for specific footwear, etc.

Emergency Contact

Name: _____ Phone: _____ Relationship:_____

_____ _____ _____ _____
Employee Date Trainer Date

Mid Oregon PERSONNEL

HEAT ILLNESS PREVENTION

What is Heat Illness?

Heat illnesses are medical conditions resulting from the body's inability to cope with a particular heat load, such as heat stroke, heat exhaustion, rhabdomyolysis, heat syncope, and heat cramps. In addition, what could seem like a mild symptom, such as heat cramps, could actually be a symptom of heat stroke and quickly turn into a serious, life-threatening emergency. It is very important to take note of any heat-related symptoms and immediately seek remedy.

Heat Stroke

Heat Stroke is the most serious heat-related illness and occurs when the body becomes unable to control its temperature. During a heat stroke event, the body's temperature starts rising very quickly, the sweat function stops working correctly, and the body is unable to cool down. If emergency treatment is not given, heat stroke can cause death or permanent disability!

Symptoms include:

- Confusion, slurred speech
- Loss of consciousness
- Hot, dry skin or excessive sweating
- Seizures
- Very high body temperature

First Aid:

- Call 911; stay with the worker until help arrives.
- Move the worker to a shaded, cool area and remove outer clothing.
- Cool the worker quickly with cold water or ice bath; wet their skin and place cold wet cloths on head, neck, armpits, and groin area, and/or soak clothing with cool water.
- Fan the air around the worker to speed cooling.

Heat Exhaustion

Heat exhaustion is the body's response to an excessive loss of water and salt, usually from extreme sweating.

Symptoms include:

- Headache
- Nausea
- Dizziness
- Weakness
- Irritability
- Thirst
- Heavy sweating and high body temperature
- Decreased urine output

First Aid:

- Get medical attention or call 911 and stay with the worker until help arrives.
- Move worker from hot area and give them cool water to drink slowly and frequently.
- Remove unnecessary clothing, including shoes and socks.
- Cool them with cold, wet cloths and/or have them wash their head, face, and neck with cold water.

Rhabdomyolysis

Rhabdomyolysis is the rapid breakdown, rupture, and death of muscle associated with heat stress and prolonged physical exertion. When the muscle tissue dies, electrolytes and large proteins are released into the bloodstream which can cause irregular heart rhythms and seizures and damage the kidneys.

Symptoms include:

- Muscle cramps and/or pain
- Abnormally dark urine (tea or cola colored)
- Weakness
- Exercise intolerance
- ❖ Could be asymptomatic

First Aid

- Stop activity and drink water.
- Seek immediate medical attention and ask to be checked for rhabdomyolysis.

Heat Syncope

Heat syncope is a fainting episode or dizziness that usually occurs with prolonged standing or sudden rising from a seated position. Dehydration and lack of acclimatization can also lead to heat syncope.

Symptoms include:

- Fainting
- Dizziness or light-headedness
- ❖ Heat syncope can be a symptom of heat exhaustion

First Aid:

- Sit or lie down in a cool place.
- Slowly drink water, clear juice, or a sports drink (non-caffeinated).

Heat Cramps

Symptoms include:

- Muscle cramps, pain, or spasms in the abdomen, arms, or legs
- ❖ Heat cramps can be a symptom of heat exhaustion

First Aid:

- Drink water and have a snack every 15-20 minutes.
- Avoid salt tablets.
- Get medical help if worker has pre-existing heart conditions, is on a low sodium diet, or if the cramps do not subside within 1 hour.

HEAT ILLNESS PREVENTION

Responding to Signs and Symptoms

Since heat illnesses can quickly progress from mild symptoms into a serious or life-threatening condition, it is critical to respond immediately. Make sure you promptly report the signs and symptoms of heat-related illnesses to your employer and/or supervisor. This will help them respond quickly to the situation, as well as to adjust the workforce or work environment if needed. If working alone, pay attention to any signs or symptoms that may be heat-related and make sure there is a way to contact help if it becomes necessary.

Personal and Non-Personal Occupational Risk Factors

There are many personal and non-occupational risk factors that can increase the body's sensitivity to heat. These are some of the risk factors, but not all.

- Heart disease
- Diabetes
- Asthma & COPD
- Obesity
- Kidney Disease
- Use of medications
- Use of drugs and/or

Acclimatization Plan: Acclimate BEFORE your shift.

Acclimatization means letting the body adjust gradually to the new climate or conditions. Typically, for a physically fit and healthy individual, the acclimatization process takes 1-2 weeks of at least 2 hours of working in the heat per day. Once acclimated to the heat, some of the beneficial adjustments include:

- more efficient sweating with less electrolytes lost,
- stabilized circulation, and
- the ability to work with a lower core temperature and heart rate.

Emergency Medical Plan: Recognize symptoms, Immediate First Aid, Call 911.

Heat Illness Prevention Plan:

- Read through Heat Illness Training completely.
- Wear appropriate clothing for the weather.
- Use a hat, sunglasses, sunscreen as needed.
- Sit in the shade.
- Drink cool or cold water.
- Request a break if you are unable to cope with a particular heat load.
- Report the signs and symptoms of heat-related illnesses to your employer and/or supervisor.
- Contact help if it becomes necessary.

Initial and sign below:

_____ I have read and understand the information outlined in this heat illness prevention training.

_____ I will follow the plan to prevent heat illness and report any signs and symptoms of heat-related illnesses to your employer and/or supervisor.

_____ _____ _____ _____

(Employee) (Date) (Employer) (Date)

References:

Understanding Your Pay Statement

Employee Name: _____ **Start Date:** _____

Host Employer:_____ **Pay Rate:** _____ **First Pay Date:** _____

Pay period:

☐ 5th/20th	1st–15th hours paid on 20th, 16th – the last day of the month paid on the 5th
☐ 10th/25th	1st–15th hours paid on 25th, 16th – the last day of the month paid on the 10th
☐ Monthly	24th– 23rd hours paid on the last day of the month
☐ LDOM/15th	25th – 9th hours paid on the 15th , 10th –24th paid on the last day of the month
☐ Bi-Weekly	Paid every other week on: ☐ Thursday ☐ Friday – for the two previous weeks
☐ Other	

Pay Week (for overtime calculation):

☐ 12:00 am on Monday through 11:59 pm on Sunday

☐ 12:00 am on Sunday through 11:59 pm on Saturday

☐ Other:_____

**If payday falls on a weekend or holiday, payday will fall on the previous business day.*

TYPES OF PAY	
REG	Regular Pay
PTO	Paid Time Off
Sick	Sick Pay
OT	Overtime
DT	Double Time
Salary XXXXXX	Salary – Monthly/Bi-weekly/Semi Monthly/Weekly/Exempt
Reported Tips	Reported Tips
Mileage	Mileage
Other Income	Other Income
Holiday	Holiday Pay
Vacation	Vacation Pay
Insurance reimbursement	Insurance reimbursement
Bonus	Bonus
Piecework	Piecework
POSSIBLE DEDUCTIONS	
FEDERAL INCOME TAX	Federal Withholding (FICA)
MED EE	Federal Medicare Employee tax
OR WH	Oregon State Income Tax Withholding
MONTANA WH	Montana State Income Tax Withholding
OREGON WORKER	Oregon WC benefit fund is withheld .1 per hour worked.
OR STATEWIDE TR	Oregon Statewide Transit Tax
OREGON PFML EE	Oregon Paid Family & Medical Leave Employee portion
WA PAID FAMILY A	Washington Paid Family & Medical Leave
WA CARES FUND	Washington Cares Fund Deduction
Other Deduction	Other Deduction
Garnishment 1,2,3	Garnishment 1,2,3 (Numbered for multiple)
Child Support 1,2,3	Child Support 1,2,3 (Numbered for multiple)
Withholding Fee	Withholding Fee
POSSIBLE CONTRIBUTIONS	
Medical/Dental/Health	Insurance Contributions (May be single or a combination)
401K/Roth 401K	401K -OR- Roth 401K Contributions

You can expect to receive an itemized pay statement with every payment of wages, commissions, or salary. We are providing this information to ensure you understand the information on your itemized pay statement. Please contact our corporate office, 541-447-1299, with any questions.

STATE MINIMUM: Oregon Sick Leave

Oregon Sick Time is paid and accrues at 1 hour per 30-hours worked and capped at 40-hours per year. Employees can start using it after 90-days, but accrual starts on day one. Oregon Sick time may or may not be frontloaded, depending on host employer preference. A maximum of 40-hours can carry over each year unless hours are frontloaded. Total accrual is capped at 80-hours. Oregon Sick Time is not paid out upon separation.

STATE MINIMUM: Washington Sick Leave

Washington Sick Time is paid to hourly employees and accrues at 1 hour per 40-hours worked and capped at 40-hours per year. Employees can start using it after 90-days, but accrual starts on day one. Washington Sick time may or may not be frontloaded, depending on host employer preference. A maximum of 40-hours can carry over each year unless hours are frontloaded. Total accrual is capped at 80-hours. Washington Sick Time is not paid out upon separation.

Your pay stub will indicate total accrued hours as required by state law, but this total does not necessarily indicate the amount available to use. Contact your host employer or Mid Oregon Personnel for your available balance.

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

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

► **Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.***

OMB No. 1545-1500

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

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

---

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► **Date**

For Employer's Use Only

Employer's name Mid Oregon Personnel Telephone no. 5414471299 EIN ▶ 93-0903486

Street address 187 NW Second Street

City or town, state, and ZIP code Prineville OR 97754

Person to contact, if different from above _____ Telephone no. _____

Street address _____

City or town, state, and ZIP code _____

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under *Members of Targeted Groups* in the separate instructions), enter that group number (4 or 6) . . . . . ▶ _____

Date applicant:

Gave information	Was offered job	Was hired	Started job

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶ **Title** **Date**

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . 6 hr., 27 min.

Learning about the law or the form . . . . . 24 min.

Preparing and sending this form to the SWA . . . . . 31 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from *www.irs.gov/formspubs.* Click on "More Information" and then on "Give us feedback." Or you can send your comments to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.

U.S. Department of Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: May 31, 2026

Work Opportunity Tax Credit
Individual Characteristics Form (ICF)

Clear Form

1. Control No. *(For Agency use only)*	**SWA / AGENCY INFORMATION** **(See instructions on pg 4)**	**2. Date Received** *(For Agency Use only)*

EMPLOYER INFORMATION		
3. Employer Name Mid Oregon Personnel	**4. Employer Mailing Address, Telephone No. and Email Address** 187 NW Second Street Prineville OR 97754	**5. Employer Identification Number (EIN)** 93-0903486

JOB APPLICANT INFORMATION		
6. Applicant Name (Last, First, MI)	**7. Social Security Number** _____ - ____ - _____	**8. Have you worked for this employer before?** **YES:** ◯ **NO:** ◯

JOB APPLICANT CHARACTERISTICS FOR WOTC TARGETED GROUP(S) CERTIFICATION		
9. Employment Start Date	**10. Starting Wage**	**11. Job Position (Title) or SOC (Standard Occupation Classification)**

Directions: Read the following statements carefully and check any of following statements that apply to the job applicant. Provide additional information where requested and as needed for targeted group eligibility determination.

12. Qualified IV-A Recipient
Check here if the job applicant is a Qualified IV-A Recipient ☐

If the job applicant is a member of a family receiving Temporary Assistance for Needy Families (TANF), enter the name of the ***primary benefits recipient:*** _____, and the ***city and state(s)*** where benefits were received: _____

13. Qualified Veteran
Check here if the job applicant is a veteran of the U.S. Armed Forces ☐

If the job applicant (veteran) is a member of a family receiving Supplemental Nutrition Assistance Program (SNAP) benefits, enter the name of the ***primary benefits recipient:*** _____,
and the ***city and state(s)*** where benefits were received: _____.
Note: Additional information may be requested to determine the job applicant's qualified veteran eligibility, such as proof of being entitled to compensation for a service-connected disability or having aggregate periods of unemployment.

14. Qualified Ex-Felon
Check here if the job applicant is an Ex-Felon ☐ **Check if the job applicant is in a Work Release Program:** ☐
Enter **date of felony conviction** *(mm/dd/yyyy)*: _____ and **release date**: _____
Federal conviction: ☐ **State conviction**: ☐ **List applicable state**: _____.

15. Designated Community Resident (DCR)

Check if the job applicant is at least age 18 but not age 40 on the hiring date, and resides in a Rural Renewal County (RRC) ☐ or an **Empowerment Zone (EZ).** ☐

Enter ***job applicant's birthday*** (mm/dd/yyyy): .

16. Vocational Rehabilitation Referral

Check here if the job applicant is a Vocational Rehabilitation (VR) Referral ☐

Applicant was referred by (select one of the following): **Rehabilitation agency approved by the state;** ☐

Employment Network under the Ticket to Work Program; ☐ **Department of Veterans Affairs** ☐

17. Qualified Summer Youth Employee

Check here if the job applicant is a Qualified Summer Youth Employee ☐

Enter the ***job applicant's birthday*** (*mm/dd/yyyy*): _____

18. Qualified Supplemental Nutrition Assistance Program (SNAP) Recipient

Check here if the job applicant is a Qualified SNAP (Food Stamps) Recipient ☐

Enter **job applicant's birthday** (*mm/dd/yyyy*):

Enter the name of the ***primary benefits recipient***: _____, and the ***city and state(s)*** where benefits were received: _____.

19. Qualified Supplemental Security Income (SSI) Recipient

Check here if the job applicant received or is receiving Supplemental Security Income (SSI) ☐

20. Long-Term Family Assistance Recipient

Check here if the job applicant is a Long-term Family Assistance (long-term TANF) recipient ☐

Enter name of the ***primary benefits recipient:*** _____, and the ***city and state(s)*** where benefits were received: _____.

21. Qualified Long-Term Unemployment Recipient

Check here if the job applicant is a qualified long-term unemployment recipient (LTUR) ☐

Enter ***city and state(s)*** where UI claim records / UI wage records were filed**:** _____

_____.

22. **Sources used to document eligibility.** List all supporting documentation submitted to SWA. Indicate next to each document listed whether it is attached (A) or forthcoming (F). **SWA Staff:** List all supporting documentation used in determining targeted group eligibility for the applicant. Enter your initials and date when the determination was made.

I certify that this information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification.

23(a). Signature: (See instructions in Box 23.(b) for who signs this signature block)	**23.(b)** Indicate who signed this form: ◯ Employer, ◯ Employer's Preparer, ◯ SWA / Participating Agency, ◯ Job Applicant, ◯ Parent/Guardian (if job applicant is a minor)	**24. Signature Date:**