Client Company: ______________________________ Pay Rate ____________

Application for Co-Employment of (Employee Name): ______________________ W/C Code ____________

Employee SSN__________________

Employee DOB__________________

SI USTED NO SABE LEER EN INGLES, SOLICITE UNA APPLICACION EN ESPANOL

The information contained in this Application is vital to your co-employment with IMPACT Staff Leasing (ISL). All documents must be filled out completely and signed by you **BEFORE** a co-employment relationship will be acknowledged. You will be considered for co-employment without regard to race, color, religion, sex, national origin or age.

I. ACKNOWLEDGEMENT AND VERIFICATION

By initialing and signing this Application for Employment I acknowledge and verify that I have received a copy of IMPACT'S policies, have read, fully understand, and agree, if hired to abide by these policies.

__________ I have been advised and understand that if I am hired, a co-employment relationship is created between IMPACT and the client company for the purposes of payroll and workers' compensation coverage. Furthermore, I understand that the client company will be my on-site employer and will direct the day-to-day activities of my employment, and controls the decision regarding any continuation or termination of my employment.

__________ I have been advised and understand that IMPACT carries workers' compensation insurance, and that I am covered by IMPACT's workers' compensation as long as I am receiving a paycheck from IMPACT. In the event my wages are paid by any means other than with a payroll check from IMPACT, I understand that I am not covered by IMPACT's workers' compensation for that pay period.

__________ I understand that any wages paid by a method other than a payroll check, pay card deposit, or direct deposit issued by ISL will not be included in any wage determinations for purposes of benefits awarded under a Workers' Compensation claim filed against ISL's policy.

II. HIPAA Authorization

I authorize IMPACT, or its agent, subsidiary or affiliate to obtain any medical records (excluding psychotherapy notes) from any physicians, hospitals and/or other health care providers concerning my care. I also authorize any physicians, hospitals, and/or other health care providers to furnish any medical records (excluding psychotherapy notes) concerning my care to IMPACT, or its agent, subsidiary or affiliate. This information is needed to evaluate my health condition and continued eligibility for employment and insurance coverage. I understand that the entities indicated above can request medical records for up to the past 10 years. I further authorize IMPACT, or its agent, subsidiary or affiliate to require me to submit to an alcohol or drug test following any on the job injury for which I seek medical treatment, and to receive the results.

I understand that I may revoke this Authorization at any time by submitting written notice to IMPACT.

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. IMPACT, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

III. Payroll Deduction Authorization

By signing below, I authorize deductions when applicable to be made out of my paycheck for tools, uniforms, health insurance, errors in payroll, overpayments and any other work related deductions allowable by law.

IV. Wage Disputes

I understand and agree that the client company is solely obligated to pay any wages for which the obligation to pay is created by an agreement, contract, plan or policy between the client company and myself and that IMPACT has not contracted to pay.

V. Arbitration

I agree that my sole recourse for resolving any dispute with IMPACT arising under my employment, including but not limited to wage claims, shall be to arbitrate such dispute. Such arbitration shall be pursuant to the arbitration laws of the State of Florida and the rules, then obtaining, of the American Arbitration Association. Venue of any action shall be in Palm Beach County, Florida. IMPACT is based in Jupiter, Florida, and Applicant acknowledges that this Agreement is to be partially performed in Jupiter, Florida.

______________________________ ____________________

Applicant Signature Date

Rev. 5/16

Form W-4 (2016)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

The exceptions do not apply to supplemental wages greater than $1,000,000.

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total taxfor 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

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

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

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job (Entering "-0-" may help you avoid having too little tax withheld) C _______

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

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

F Enter "1" if you have at least $1,900 of child or dependent care expenses for which you plan to claim a credit F ___
(Note. Do not include child support payments See Pub 503, Child and Dependent Care Expenses, for details)

G Child Tax Credit (including additional child tax credit) See Pub 972, Child Tax Credit, for more information
• If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children
• If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child 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 are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld
• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below }

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

Form **W-4**
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

2016

1 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 replacement 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 2016, 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
(This 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)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►**START HERE.** **Read instructions carefully before completing this form. The instructions must be available during completion of this form.**
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-__-____		

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

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

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ____________________

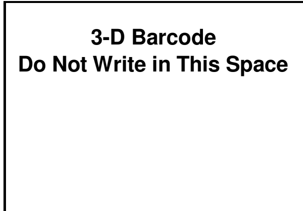
☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy)______________. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number:____________________

OR

2. Form I-94 Admission Number: ____________________


3-D Barcode
Do Not Write in This Space

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________________

Country of Issuance: ____________________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

Signature of Employee:	Date *(mm/dd/yyyy):*

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.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

Employer Completes Next Page

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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

3-D Barcode
Do Not Write in This Space

Certification

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

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

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative	
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name	
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

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

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

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

IMPACT STAFF LEASING
SUBSTANCE ABUSE POLICY

(Spanish version available upon request)

EMPLOYEE IS TO KEEP THIS PAGE

The welfare and success of IMPACT, the "Company", depends on the physical and psychological health of all its employees. While the Company is committed to maintaining a safe and productive workplace, it is the responsibility of both the Company and the employees to create and maintain a safe, healthful and efficient working environment. Therefore, for the protection of its clients, employees, property and the general public, the Company has adopted this Substance Abuse Policy.

1. PURPOSE AND SCOPE

1.1 **PURPOSE:** The purpose of this policy is to maintain a safe, healthful and efficient working environment by eliminating any abuse of legal and illegal drugs, alcohol and inhalants on the Company premises or a t any time while on Company business, and requiring all employees of the Company to be free from the effects of legal and illegal drugs, alcohol and inhalants while on the Company premises or at any time while on Company business.

1.2 **SCOPE:** This policy applies to all employees of this Company; (a) at all times while on the Company premises, (b) during the course and scope of their employment regardless of location and (c) during any Company-sponsored activities.

2. DISCIPLINARY ACTION AND PROHIBITED CONDUCT

2.1 **DISCIPLINARY ACTION:** An employee's failure to comply with any part of this policy will result in disciplinary action up to and including termination of employment.

2.2 **PROHIBITED CONDUCT:** Any employee will be subject to the above measures of Paragraph 2.01 for any of the following:

a). The manufacture, distribution, possession, use or sale of alcohol, inhalants, unauthorized or illegal drugs or the misuse of any legal or prescription drugs on Company premises, while on Company business, or during any Company-sponsored activities.
b). Being under the influence of any substance described (a) above which impairs judgment, performance or behavior while on Company premises, while on Company business, or during Company-sponsored activities.
c). Conviction under any criminal stature for the possession, use or sale of drugs or alcohol or any related activity.
d). Refusing to submit to a medical evaluation, including drug or alcohol testing as provided for in Section 3 of this policy.
e). Generating test results which indicate any drug, alcohol or other substance abuse.

3. TESTING

3.1 **DEFINITION:** For the purpose of this Policy, "drug" is defined as any alcoholic beverage, illegal inhalant, illegal drug or other substance, the use, possession, manufacture, distribution or dispensation of which is prohibited by any state or federal law or regulation and any drug substance obtained by prescription, over-the-counter or otherwise.

3.2 **APPLICABILITY OF DRUG TESTING:**
a). All persons applying for a position with the Company may be required to submit to a drug test as a condition of employment.
b). All current and future employees must submit to a drug test upon the request of the Company under the following:

1) When special safety conditions are vital to obtain the job indicated and such testing presents a reasonable means to assure a safe working environment.
2) When the employee either sustains an injury in the course and scope of employment or contributes to or causes another employee to sustain an injury in the course and scope of employment.
3) When the employee causes, indirectly or directly, damage to the Company's property or to the property of another.
4) When the employee contributes or causes injury to any third party while the employee is in the course and scope of employment.
5) When the employee is convicted under any criminal drug statute for a violation occurring during the course and scope of employment. If such a conviction occurs, it is the employee's responsibility to notify the Company within five (5) days of the conviction. This requirement includes any finding of guilt, guilty plea of no contest or imposition of sentence or any other penalty whatsoever by any court of competent jurisdiction or otherwise in connection with any state or federal criminal statute involving the manufacture, distribution, dispensation, use or possession of any controlled substance or drug, including alcohol.
6) When the Company, in its sole discretion, determines that it is in the Company's best interest to conduct such a drug test.

4. MISCELLANEOUS PROVISIONS

4.1 **COOPERATION WITH LAW ENFORCEMENT:** In addition, any illegal drug or other substance obtained by the Company from any employee may be turned over to a law enforcement agency and may result in criminal prosecution.

4.2 **REPORTING:** Each employee is responsible for promptly reporting to the appropriate Company officers any use of prescribed medication which may affect the employee's judgment, performance, or behavior.

4.3 **OTHER PROCEDURES:** The Company will establish such other procedures as it finds necessary to effectively enforce this policy. This may include a requirement that employees cooperate in personal or facility searches when there is reason to believe drugs or alcohol are present, when their performance is impaired or when their behavior is erratic. Refusing to cooperate with these procedures may be cause for disciplinary action as provided in Section 2.

4.4 **MEDICAL FACILITY:** The Company shall not be responsible for and makes no representations or warranties on behalf of the laboratory or medical facility conducting the drug test.

IMPACT STAFF LEASING

ACCIDENTS / INJURIES PROCEDURES
(Spanish version available upon request)

EMPLOYEE IS TO KEEP THIS PAGE

The following procedures must be followed for all work related injuries:

1. ALL ACCIDENTS/INJURES MUST BE REPORTED TO THE FOREMAN OR SUPERVISOR, EVEN IF NO MEDICAL ATTENTION IS REQUIRED. The injured employee must complete the form entitled: Employee Incident Report. Once completed, the form will be placed in the employee's medical file for future reference. Please fax this form to (561) 748-3235.

2. The foreman/supervisor, must complete a Supervisor's Report of Accident form regardless of whether or not medical attention is required for the injured employee. Please fax this form to (561) 748-3235.

3. Should the injury require medical attention, however, is not an emergency situation, have the foreman/super call the new injury dept. at (561) 743-0065 prior to seeking a medical facility. In case of an emergency, have the foreman/super call and report which medical facility the employee is being transported to. It is important that IMPACT authorizes treatment, arranges proper billing, and determines that the facility follows proper procedures.

4. Should an employee be off of work and on disability, he/she must notify his or her foreman/supervisor. Should the employee be off for an extended period of time, the employee must check in with his or her office by visiting or calling in at least once a week. IMPACT must be advised of the employee's status. Upon
receiving a release to return to work, the employee is required to call his or her jobsite to report his or her availability.

5. Doctor's restrictions must be followed for all employees on light duty. The employee may return to his/her regular duties only when a release is provided to IMPACT in writing by the doctor. It is the employee 's responsibility to inform their doctor about the types of light duty work IMPACT provides.

6. An alcohol and drug screen is required for all injuries. The test is required to be taken within 24 hours after an injury is reported. Refusal to submit a drug test will result in affirmation to a positive drug and alcohol test.

7. I understand and agree to abide by the above accident procedures. I understand that any payments to me or to anyone else for expenses in connection with my accident and resulting injury are not an admission of liability on the part of IMPACT. In the event of an injury, I authorize full access to copies of medical records, radiology reports, drug/alcohol screenings and documents of any kind relating to my past or present injury/illness to IMPACT. I hereby agree to release this information and hold all such medical providers harmless from the release of this information as set forth in this authorization statement.