This document can be filled in electronically and printed using Adobe Acrobat Reader, which can be downloaded for free from the Adobe web site at https://get.adobe.com/reader

SOUTH EAST PERSONNEL LEASING, INC. (SPLI*) EMPLOYEE LEASING APPLICATION

(SOLICITUD PARA CONTRATO DE EMPLEADOS ARRENDADOS)

Payroll Fax: **(727) 437-0000**

*_____ _____

Client Company Name (Compañia del Cliente) **Location** (Ubicación) **(if multiple client locations/offices exist)**

SECTION 1 – TO BE COMPLETED BY THE APPLICANT (SECCIÓN 1 – PARA SER COMPLETADO POR EL SOLICITANTE)

*_____ *_____ _____ *_____

Last Name (Apellido) **First Name** (Primer Nombre) **MI** (Initial del segundo) **SSN** (Numero de Seguro Social)

*_____ _____ *_____ *_____ *_____

Applicant Address (Dirección del Solicitante) **Apt/Lot/etc** (Apt. o lote) **City** (Ciudad) **State** (Estado) **Zip Code** (Codigo postal)

_____ *_____ _____

Phone Number (Numero de Teléfono) **Birthdate** (Fecha de Nacimiento) **Email Address** (Correo Electrónico)

EEO Data: We are subject to certain government recordkeeping and reporting requirements for the administration of civil rights laws and regulations. To comply with these laws, we invite you to voluntarily self-identify your race or ethnicity and gender. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual. (Nosotros estamos sujetos a ciertos requerimientos de compilación de datos y reportes para la administración de leyes y regulaciones de los derechos civiles. Para cumplir con estas leyes, te invitamos a voluntariamente identificar tu raza y género. Proveer está información es voluntario y negarse a suministrarla no traerá ninguna consecuencia adversa. La información obtenida se mantendrá confidencial y solamente se utilizara de acuerdo con las leyes aplicables, ordenanzas y regulaciones ejecutivas incluyendo aquellas que requieren el resumen y reporte de la información al gobierno federal para el cumplimiento de derechos civiles. Cuando se reporten, estos datos no identificaran a ningún individuo en específico.)

Gender: ☐ **M** ☐ **F** **Ethnicity:** ☐ **White/ Caucasian** ☐ **Black/African American** ☐ **Hispanic/ Latino** ☐ **Asian** ☐ **American Indian/ Alaskan Native** ☐ **Hawaiian/ Pacific Islander** ☐ **Two or More Races**

I understand and agree to the following: I am not yet a leased employee of SPLI. If I suffer an injury or have suffered an injury related to work while working for the Client Company but before I am accepted as a leased employee by SPLI, the Client Company (not SPLI) will be responsible for providing Workers' Compensation Coverage, even if I am paid by SPLI or subsequently accepted as an employee of SPLI. I will not be accepted as an employee of SPLI, and workers' compensation coverage will not be provided by SPLI for any accidents until after all pages of the SPLI Employee Leasing Application are completed and signed by me, the complete SPLI Employee Leasing Application is delivered to SPLI, and SPLI accepts me as a leased employee. The SPLI Employee Leasing Application includes all the following documents: This page, the Applicant Acknowledgment, Safe Working Practices Acknowledgment, Acknowledgment of the Post Accident/Reasonable Suspicion Program, Acknowledgment of Alcohol and Drug Policy, Arbitration Agreement, Form I-9, Form W-4, and Form NJ-W4. The complete Form I-9 and Form W-4, including instructions, can be obtained at https://spli.com/docs.php. (Yo entiendo y estoy de acuerdo con lo siguiente: Aún no soy un empleado contratado de SPLI. En consecuencia, si yo sufriera una lesión o hubiera sufrido una lesión relacionada con el trabajo mientras trabajaba para la Compañía Cliente y antes de ser aceptado como un empleado contratado por SPLI, la Compañía Cliente será responsable de esa lesión. No se procesará la Planilla de Pago y no se proporcionará cobertura de Compensación Obrera hasta y a menos que todas las páginas de la aplicación de SPLI para contrato de empleados, hayan sido llenadas y firmadas por el Solicitante, se haya sido entregada a SPLI y SPLI haya aceptado al Solicitante como un empleado contratado. La Solicitud de SPLI de Contratación de Empleados incluye la totalidad de los siguientes documentos: Esta página, el Reconocimiento del Solicitante, Reconocimiento de Prácticas de Seguridad en el Trabajo, Reconocimiento del Programa de Sospecha Razonable Posterior al Accidente, Reconocimiento de Poliza de Alcohol y Droga, Acuerdo de Arbitraje, Formulario I-9, Formulario W-4, y Formulario NJ-W4. La versión completa del Formulario I-9 y el Formulario W-4, incluyendo las instrucciones, se pueden obtener en https://spli.com/docs.php.)

*_____ *_____

Applicant Signature (Firma del Solicitante) **Date (Fecha)**

SECTION 2 – TO BE COMPLETED BY THE CLIENT COMPANY (SECCIÓN 2 – PARA SER COMPLETADO POR EL CLIENTE)

*_____ * _____

Original Client Hire Date (Fecha original de empleo el Cliente) **Job Description** (Descripción del Trabajo)

*_____ _____ _____ _____

Work State (Estado de Trabajo) **W/C Code** (Codigo de Trabajo) **Home Department** (Departamento) **Employee ID** (ID de Empleado)

* **Pay Rate and Method -** Must comply with FLSA guidelines (Tasa y método de pago - debe cumplir con FLSA directrices)

☐ Hourly (por Hora) $ _____

☐ Salary (Salario) $ _____ ☐ Check if salary employee qualifies for OT exemption (empleado califica para la excepción de horas extras)

☐ Commission/Piecework (Comisión/Pagos por pieza)

* **Pay Cycle** (Ciclo de Paga)

☐ Weekly (Semanal)

☐ Bi-Weekly (Quincenal)

☐ Other (Otros): _____

* **Employment Type** (Tipo de Empleo)

☐ Full-Time (> 30 hours avg. per week) - empleado a tiempo completo (promedio > 30 hrs por semana)

☐ Part-Time (< 30 hours avg. per week) - empleado a tiempo parcial (promedio < 30 hrs por semana)

☐ Variable (cannot determine if the EE will avg. at least 30 hours per week) - horas variables (no se puede determinar si el empleado va promediar al menos 30 hrs por semana)

☐ Seasonal (< 6 consecutive months worked during calendar year) - empleado de temporada (trabajando 6 meses consecutivos durante el año calendario)

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

2024

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, 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 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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

Form **NJ-W4**
(1-21)

State of New Jersey – Division of Taxation
Employee's Withholding Allowance Certificate

1. SS#			2. Filing Status: (Check only one box) 1. ☐ Single 2. ☐ Married/Civil Union Couple Joint 3. ☐ Married/Civil Union Partner Separate 4. ☐ Head of Household 5. ☐ Qualifying Widow(er)/Surviving Civil Union Partner
Name			
Address			
City	State	Zip	

3. If you have chosen to use the chart from instruction A, enter the appropriate letter here	3.
4. Total number of allowances you are claiming (see instructions)	4.
5. Additional amount you want deducted from each pay	5. $
6. I claim exemption from withholding of NJ Gross Income Tax and I certify that I have met the conditions in the instructions of the NJ-W4. If you have met the conditions, enter "EXEMPT" here	6.

7. Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate or entitled to claim exempt status.

Employee's Signature _____ Date _____

Employer's Name and Address _____ Employer Identification Number _____

BASIC INSTRUCTIONS

Line 1 Enter your name, address, and Social Security number in the spaces provided.

Line 2 Check the box that indicates your filing status. If you checked Box 1 (Single) or Box 3 (Married/Civil Union Partner Separate) you will be withheld at Rate A.
Note: If you have checked Box 2 (Married/Civil Union Couple Joint), Box 4 (Head of Household) or Box 5 (Qualifying Widow(er) Surviving Civil Union Partner) and either your spouse/civil union partner works or you have more than one job or more than one source of income and the combined total of all wages is greater than $50,000, see instruction A below. If you do not complete Line 3, you will be withheld at Rate B.

Line 3 If you have chosen to use the wage chart below, enter the appropriate letter.

Line 4 Enter the number of allowances you are claiming. Entering a number on this line will decrease the amount of withholding and could result in an underpayment on your return.

Line 5 Enter the amount of additional withholdings you want deducted from each pay.

Line 6 Enter "EXEMPT" to indicate that you are exempt from New Jersey Gross Income Tax Withholdings, if you meet one of the following conditions:

- Your filing status is **SINGLE** or **MARRIED/CIVIL UNION PARTNER SEPARATE** and your wages plus your taxable nonwage income will be $10,000 or less for the current year.
- Your filing status is **MARRIED/CIVIL UNION COUPLE JOINT**, and your wages combined with your spouse's/civil union partner's wages plus your taxable nonwage income will be $20,000 or less for the current year.
- Your filing status is **HEAD OF HOUSEHOLD** or **QUALIFYING WIDOW(ER)/SURVIVING CIVIL UNION PARTNER** and your wages plus your taxable nonwage income will be $20,000 or less for the current year.

Your exemption is good for ONE year only. You must complete and submit a form each year certifying you have no New Jersey Gross Income Tax liability and claim exemption from withholding. If you have questions about eligibility, filing status, withholding rates, etc. when completing this form, call the Division of Taxation's Customer Service Center at (609) 292-6400.

Instruction A - Wage Chart

This chart is designed to increase withholdings on your wages, if these wages will be taxed at a higher rate due to inclusion of other wages or income on your NJ-1040 return. **It is not intended to provide withholding for other income or wages.** If you need additional withholdings for other income or wages, use Line 5 on the NJ-W4. This Wage Chart applies to taxpayers who are married/civil union couple filing jointly, heads of households, or qualifying widow(er)/surviving civil union partner. **Single individuals or married/civil union partners filing separate returns do not need to use this chart.** If you have indicated filing status #2, 4 or 5 on the above NJ-W4 and your taxable income is greater than $50,000, you should strongly consider using the Wage Chart. (See the Rate Tables on the reverse side to estimate your withholding amount.)

HOW TO USE THE CHART

1) Find the amount of your wages in the left-hand column.

2) Find the amount of the total for all other wages (including your spouse's/civil union partner's wages) along the top row.

3) Follow along the row that contains your wages until you come to the column that contains the other wages.

4) This meeting point indicates the Withholding Table that best reflects your income situation.

5) If you have chosen this method, enter the "letter" of the withholding rate table on Line 3 of the NJ-W4.

NOTE: If your income situation substantially increases (or decreases) in the future, you should resubmit a revised NJ-W4 to your employer.

THIS FORM MAY BE REPRODUCED

WAGE CHART

Total of All Other Wages		0 10,000	10,001 20,000	20,001 30,000	30,001 40,000	40,001 50,000	50,001 60,000	60,001 70,000	70,001 80,000	80,001 90,000	OVER 90,000
YOUR WAGES	0 10,000	B	B	B	B	B	B	B	B	B	B
	10,001 20,000	B	B	B	B	C	C	C	C	C	C
	20,001 30,000	B	B	B	A	A	D	D	D	D	D
	30,001 40,000	B	B	A	A	A	A	A	E	E	E
	40,001 50,000	B	C	A	A	A	A	A	E	E	E
	50,001 60,000	B	C	D	A	A	A	E	E	E	E
	60,001 70,000	B	C	D	A	A	E	E	E	E	E
	70,001 80,000	B	C	D	E	E	E	E	E	E	E
	80,001 90,000	B	C	D	E	E	E	E	E	E	E
	OVER 90,000	B	C	D	E	E	E	E	E	E	E

NJ-165
9-19

STATE OF NEW JERSEY
Department of the Treasury
Division of Taxation
PO Box 269
Trenton, NJ 08695-0269

Employee's Certificate of Nonresidence In New Jersey

Print or Type

First Name	MI	Last Name	Social Security Number
Street Address			
City		State	ZIP Code

Pennsylvania Residents

I hereby declare, under penalties of perjury, that I am a resident of the State of Pennsylvania and that, pursuant to a reciprocal agreement existing between that State and the State of New Jersey, I claim exemption from withholding of New Jersey Gross Income Tax on compensation paid to me in the State of New Jersey and authorize my employer to withhold Pennsylvania personal income taxes on my behalf.

Note: If you change your residence from Pennsylvania to any other state, you must notify your employer within 10 days.

Date _____ Signature _____

Military Spouses

Under the Servicemember Civil Relief Act (SCRA), as amended by the Military Spouses Residency Relief Act, you may be exempt from New Jersey Income Tax on your wages if you reside in New Jersey but have chosen a state other than New Jersey as your legal residence. If you claim exemption under the SCRA, attach a copy of your spousal military identification card to Form NJ-165.

I certify that I am not subject to New Jersey withholding. I meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act.

Date _____ Signature _____

New Jersey Employer

You are required to have a copy of this form on file for each employee receiving compensation paid in New Jersey and who is a resident of Pennsylvania and claims exemption from withholding of New Jersey Gross Income Tax under the reciprocal agreement between New Jersey and Pennsylvania or who claims exemption from withholding of New Jersey Gross Income Tax under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act. **Do not forward this Form to the Division of Taxation.**

This Form May Be Reproduced

Do Not Forward This Form To The Division of Taxation

Download Instructions

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

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. A noncitizen (other than **Item Numbers 2.** and **3.** above) 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

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

When completing electronically, the employee must first select a Citizenship/Immigration Status in Section 1 above before you can complete this section

☐ 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

I. APPLICANT ACKNOWLEDGMENT - I, the undersigned applicant, acknowledge by my signature that I have been informed that if accepted as a leased employee of SPLI I will be leased to: _____ (Client Company). I further understand that if accepted as a leased employee of SPLI, either SPLI or I can terminate our relationship at any time, as I will be an at-will leased employee of SPLI. I also understand and agree that if accepted, while I am a leased employee of SPLI, if SPLI does not receive payment from the Client Company for services which I perform, SPLI will still pay me the applicable minimum wage (or the legally required overtime pay, at the applicable minimum wage rate, in a workweek in which I have worked overtime) for any such pay period and I agree to this method of compensation. As a term of employment with SPLI, I understand and agree that all of my compensation for work done for the Client Company must be paid by SPLI. It is expressly prohibited for me to accept compensation from any source other than SPLI for work done for the Client Company without the express written consent from SPLI. The moment I accept compensation from any source other than SPLI for work performed for the Client Company without SPLI's written consent, my employment with SPLI will be automatically terminated/dissolved, effective the beginning of the pay period in which I received that compensation, even if SPLI is not yet aware of it and even if SPLI continues to pay me. Therefore, I understand and agree that if I receive any compensation from any source other than SPLI for work done for the Client Company without SPLI's written consent, I will be considered an employee of that source and not an employee of SPLI. I understand and agree that this means that if I get paid by any source other than SPLI for work done for the Client Company without SPLI's written consent and I get hurt while working, I will not be an employee of SPLI and will, therefore, not be covered by SPLI or SPLI's workers' compensation policy. This paragraph does not apply to tips from patrons. I also agree to comply with any drug/alcohol testing policy, which SPLI has or may adopt. I specifically agree to post-accident drug/alcohol testing after every work injury regardless of whether I am able to give consent at that time. This document is my authority to post-accident drug/alcohol testing in all instances. SPLI is in agreement with the Federal Government that marijuana is a controlled substance and will not recognize medical marijuana as a legitimate prescription. A positive test result for marijuana will be treated the same as any other positive test result, even if an employee has a medical marijuana prescription. I acknowledge that I am required to promptly report all incidents of discrimination, harassment, or retaliation, regardless of the offender's identity or position, to the Client Company. I further acknowledge that the Client Company is responsible for investigating my complaint and taking appropriate action, if any is determined to be necessary, to end or remediate the discrimination or retaliation. I further acknowledge and agree that because SPLI does not have actual control over my work with the Client Company, and as such is not in a position to know of any alleged discrimination, harassment, or retaliation, all action to end or remediate any discrimination, harassment, or retaliation must come solely from the Client Company.

I. RECONOCIMIENTO DEL SOLICITANTE - Yo, el solicitante infrascrito, reconozco atravez de mi firma que se me ha informado que si me aceptan como un empleado arrendado por SPLI seré arrendado a: _____ (Compañía del Cliente). Al igual entiendo que si me aceptan como empleado arrendado de SPLI, cualquier SPLI o Yo podemos terminar nuestra relación en cualquier momento, ya que seré un empleado arrendado de SPLI por mi propia voluntad. Yo también entiendo y estoy de acuerdo que si soy aceptado, mientras sea un empleado arrendado de SPLI, si SPLI no recibe pago por parte de la Compañía del Cliente por los servicios que yo preste, SPLI me pagara el salario mínimo aplicable (o el pago por tiempo extra exigido por la ley, a la tasa de salario aplicable en una semana de trabajo durante la cual yo haya laborado tiempo extra) por cualquier periodo de pago y yo estoy de acuerdo con este método de Compensación. Como un término de empleo con SPLI, yo entiendo y estoy de acuerdo que toda mi Compensación por trabajo prestado mediante a la Compañía del Cliente debe de ser pagada atravez de SPLI. Esta expresamente prohibido el aceptar Compensación de cualquier otra fuente que no sea SPLI por trabajo prestado para la Compañía del Cliente sin el consentimiento por escrito de SPLI. En el momento que Yo acepte Compensación de otra fuente que no sea SPLI por trabajo prestado para la Compañía del Cliente sin el consentimiento por escrito de SPLI, mi empleo con SPLI será automáticamente terminado/disuelto, efectivamente iniciando el periodo de pago en el cual Yo recibí la Compensación, aun si SPLI no este enterado de esto y aun si SPLI continué pagándome. Por lo tanto, Yo entiendo y estoy de acuerdo que si Yo recibo cualquier Compensación de cualquier fuente aparte de SPLI por trabajo prestado para la Compañía del Cliente sin el consentimiento por escrito de SPLI, Yo seré considerado un empleado de esa fuente y no un empleado de SPLI. Yo entiendo y estoy de acuerdo que esto significa que si Yo recibo pago de otra fuente que no sea SPLI por trabajo prestado para la Compañía del Cliente sin el consentimiento por escrito de SPLI y me lastimo mientras estoy haciendo mi trabajo, no seré un empleado de SPLI y por lo tanto no seré cubierto por SPLI o por la póliza de Compensación de obreros de SPLI. Este párrafo no se aplica a las propinas de patrones. Yo también estoy de acuerdo en cumplir con cualquier póliza de pruebas de drogas, la cual SPLI pueda adoptar. Yo específicamente estoy de acuerdo en la prueba de drogas después de cada accidente en el trabajo aunque Yo no pueda dar consentimiento en ese momento. Este documento es mi autorización a una prueba de drogas después de un accidente de trabajo en cualquier caso. SPLI está de acuerdo con el gobierno federal que la marijuana es una substancia controlada y no reconocerá la marijuana médica como prescripción legítima. Un resultado de prueba positivo para la marijuana sera tratada igual que cualquier otro resultado de prueba positivo, aunque el empleado tenga una prescripción médica para la marijuana. Yo reconozco que es requerido que reporte prontamente al a Compañía del Cliente, todos incidentes de discriminación, acoso, o venganza, no importa la identificación o posición del ofensor. Yo también reconozco que la Compañía del Cliente es responsable de investigar mis quejas y tomar la acción apropiada, si determinada necesaria, para terminar o remediar la discriminación o venganza. Al igual reconozco y estoy de acuerdo que ya que SPLI no tiene el control actual sobre mi trabajo con la Compañía del Cliente, y como tal no está en posición de saber sobre cualquier alegación de discriminación, acoso, o venganza, todas las acciones para terminar o remediar cualquier discriminación, acoso o venganza deben venir totalmente de la Compañía del Cliente.

II. SAFE WORKING PRACTICES ACKNOWLEDGMENT

1. I agree to follow all safety requirements, procedures and practices, including but not limited to those imposed or recommended by: any government entity, OSHA, Client Company, SPLI or any other entity whatsoever without exception.
2. I agree to report any work-related accident, or injury, to my supervisor with the Client Company as soon as it occurs, without exception.
3. If I need treatment for a work-related injury, I agree to:
   a. Notify my supervisor with the Client Company of the need for treatment.
   b. Only go to Client Company/SPLI directed physicians for the initial treatment.
   c. On the initial visit, hand carry a Medical Authorization for Treatment form to the authorized treating facility.
   d. Notify SPLI or SPLI's workers' compensation carrier when I am referred to any specialist for treatment.
   e. Only go to SPLI or SPLI's workers' compensation carrier's directed specialists for care.

I understand that failure on my part, to follow the above procedures, could result in disciplinary action, not to exclude termination! I agree to inform SPLI of any safety violations I encounter in the workplace. I understand if I do not report my accident to SPLI within 30 days, my claim may be denied for lack of notice.

II. RECONOCIMIENTO DE PRACTICAS DE SEGURIDAD DE TRABAJO

1. Yo convengo en seguir todos los requerimientos, procedimientos y prácticas, incluyendo y no limitada a esas impuestas o recomendadas por: cualquier entidad gubernamental, OSHA, Compañía del Cliente, SPLI o cualquier otra entidad cualquiera sin excepción.
2. Yo convengo en reportar cualquier accidente relacionado al trabajo, o lesión, a mi supervisor de la Compañía del Cliente tan pronto como ocurra, sin excepción.
3. Si Yo necesito tratamiento médico por una lesión relacionada al trabajo, Yo convengo a:
   a. Notificar a mi supervisor de la Compañía del Cliente de la necesidad de tratamiento médico.
   b. Solo ver un médico asignado por la Compañía del Cliente/SPLI para el tratamiento inicial.
   c. En la visita inicial, llevar el formulario Autorización Medica para Tratamiento, para autorizar a esa facilidad proveer tratamiento médico.
   d. Notificar a SPLI o portador de Compensación de obreros de SPLI cuando haya sido referido a un especialista para tratamiento médico.
   e. Solo ir a especialistas para tratamiento dirigido por SPLI o por el portador de Compensación de obreros de SPLI.

Yo entiendo que sería una falta de mi parte, si no he de seguir los procedimientos mencionados anteriormente, y puede resultar en una acción disciplinaria, no excluye terminación. Yo convengo a informar a SPLI de cualquier violación a la seguridad que yo encuentre en el lugar de trabajo. Yo entiendo si no reporto mi accidente a SPLI en el plazo de 30 días, mi demanda puede ser negado por falta de aviso.

III. ACKNOWLEDGMENT OF THE POST-ACCIDENT/REASONABLE SUSPICION PROGRAM

I understand that SPLI maintains a Post-Accident/Reasonable Suspicion Program requiring all leased employees to report to work in a substance free condition. I have read, or had read to me, a copy of this policy and I understand the consequences of violating the policy, including my obligations under the Post-Accident/Reasonable Suspicion Policy. If I did not understand the policy, I have asked for and have received an explanation. I specifically understand that if I am injured on the job and have a confirmed positive test result; refuse to consent or submit to a drug or alcohol test; tamper with or adulterate a drug and/or alcohol specimen, refuse to authorize the release of drug or alcohol test results to SPLI, or otherwise violate this policy I may forfeit all benefits under this state's workers' compensation and unemployment compensation laws. SPLI is in agreement with the Federal Government that marijuana is a controlled substance and will not recognize medical marijuana as a legitimate prescription. A positive test result for marijuana will be treated the same as any other positive test result, even if an employee has a medical marijuana prescription. I understand that as a condition of my continued employment, where reasonable suspicion of drug and/or alcohol use exists, SPLI will require me to undergo substance screening by urinalysis for drugs and blood for alcohol. I hereby agree to submit to such tests including follow up to rehabilitation testing and the required post-accident testing. I further consent to the results of any such drug or alcohol tests being released to SPLI's authorized representative by the Medical Review Officer (MRO). I understand that I am legally authorized to receive a copy of this consent form if requested. The results will not be released to any additional parties without my written authorization, except I acknowledge that SPLI, agents of SPLI'S, and the testing laboratory will have access to the test results and may disclose such results to its attorney in connection with workers' compensation proceedings, and may use the test results when relevant to its defense in other civil or administrative matters. I release any testing facility personnel and/or any physicians who have tested me from any liability arising from a release or use of any and all test results, written reports, medical records and data concerning my test(s) to the appropriate SPLI officials. I further release all SPLI officials from liability arising from the release or use of the test results. I also understand that the Post-Accident/Reasonable Suspicion Policy and related documents are not intended to constitute a contract between the SPLI and me. I acknowledge receipt of a copy of this policy.

III. RECONOCIMIENTO DEL PROGRAMA DE SOSPECHA RAZONABLE POSTERIOR AL ACCIDENTE - Yo entiendo que SPLI mantiene el Programa de Sospecha Razonable Posterior al Accidente requiriendo que todos los empleados arrendados se reporten al trabajo en condición libre de drogas. He leido, o me han leido, una copia de esta póliza y Yo entiendo las consecuencias de violar la póliza, incluyendo mis obligaciones de la póliza del Programa de Sospecha Razonable Posterior al Accidente. Si Yo no entendi la póliza, he pedido y he recibído una explicacion. Yo específicamente entiendo que si me lesióno en el trabajo y rechazo someterme a una prueba de drogas o alcohol o mi resultado es positivo, Yo de tal modo puedo perder mi eligibilidad a todos los beneficios medicos, e indemnificacion de Compensación de obreros. Yo entiendo que como una condición para continuar mi empleo, donde hay sospecha razonable de uso de drogas y o de alcohol, SPLI requerira que Yo me someta a una prueba urinaria de drogas y de sangre para alcohol. Yo convengo a someterme a estas prubas incluyendo seguimiento pruebas de rehabilitacion y las pruebas requeridas después de un accidente. SPLI está de acuerdo con el gobierno federal que la marijuana es una substancia controlada y no reconocerá la marijuana médica como prescripción legítima. Un resultado de prueba positivo para la marijuana será tratada igual que cualquier otro resultado de prueba positivo, aunque el empleado tenga una prescripción médica para la marijuana. Yo doy consentimiento a que los resultados de cualquier prueba de droga o alcohol hechas por un Oficial de Revisión Médica sean entregada al representate autorizado de SPLI. Yo entiendo que yo estoy

legalmente autorizado a recibir una copia de este consentimiento en el caso de que yo lo requiera. El resultado no sera entregado a ningun partido adicional sin mi autorizacion por escrito, excepto Yo convengo que SPLI, agentes de SPLI, y el laboratorio de pruebas tendran acceso al resultado de la prueba y que puedan divulgar este resultado con sus abogados en coneccion a procedimientos de Compensación de obreros, y puedan usar el resultado de la prueba cuando sea revelante a su defensa en casos civiles o administrativos. Yo libero a cualquier personal de la facilidad de pruebas y o cualquier medico quien me haya tomado la prueba de cualquier responsabilidad proveniente de la entrega o de usar cualquier y todos los resultados, reportes escritos, expedientes medicos y datos que traten sobre mi prueba(s) a los oficiales apropiados de SPLI. Yo también libero a todos los oficiales de SPIL de cualquier responsabilidad proveniente de la comunicación o uso de tales resultados. Yo también entiendo que la Póliza del Programa de Sospecha Razonable Posterior al Accidente y los documentos relacionados no están intencionados para constituir un contrato entre SPLI y Yo. Yo reconozco haber recibído una copia de esta póliza.

IV. ACKNOWLEDGMENT OF ALCOHOL AND DRUG POLICY - SPLI has recognized that drug and alcohol abuse is a social problem, as well as a problem on the job site. We believe the abuse of alcohol and use of illegal drugs endangers the health and safety of the abuser(s) as well as others in the immediate area. SPLI is committed to maintaining a Post-Accident / Reasonable Suspicion Program without jeopardizing the job security of valued, but troubled employees, provided they seek help. Complying with SPLI's Post Accident / Reasonable Suspicion Program, as a condition of employment, requires an employee to refrain from reporting to work or working with the presence of illegal drugs or alcohol in his/her body. This prohibition includes the possession, use, or sale of illegal drugs and the abuse of alcohol. Company sponsored events or social activities, at which alcoholic beverages are served and consumed, will not be considered alcohol abuse just because alcohol is served. Employees, who are on the job site, under the influence of alcohol or illegal drugs are violating this policy and may be terminated. To maintain a safer and more rewarding place to work, it is important that we work together when dealing with a substance abuse problem.

IV. RECONOCIMIENTO DE POLIZA DE ALCOHOL Y DROGA - SPLI reconoce que el abuso de drogas y alcohol es un problema social, al igual que un problema en el lugar de trabajo. Nosotros creemos que el abuso de alcohol y el uso de drogas ilegales ponen en peligro la salud y seguridad del abusador(es) al igual que los demás en su área inmediata. SPLI esta comprometido a mantener un Programa de Sospecha Razonable Posterior al Accidente sin poner en riesgo la seguridad de empleados valiosos, pero que tiene problemas, siempre y cuando estos soliciten ayuda. Al cumplir con el Programa de Sospecha Razonable Posterior al Accidente de SPLI, como condición de empleo, requiere que el empleado se abstenga de presentarse a trabajar o que trabaje con la presencia de drogas ilegales o alcohol en su cuerpo. Esta prohibición incluye a la posesión, uso, o venta de drogas ilegales y del abuso de alcohol. Actividades socialeas realizadas por la compañía en las cuales se sirven y se consumen bebidas alcoholicas no seran consideras como abuso de alcohol solo por que se sirva alcohol Empleados, que estén en el lugar de trabajo, bajo la influenza de alcohol o drogas ilegales están violando esta póliza y pueden ser despedido. Para mantener un lugar de trabajo seguro y gratificante, es importante que trabajemos unidos cuando estemos tratando con este problema de abuso de substancias.

V. ARBITRATION AGREEMENT - Please read this document carefully. It describes how employment disputes, if any, will be handled if they cannot be resolved internally. By accepting employment, you are agreeing to the terms of this Arbitration Agreement ("Agreement"). You agree and acknowledge that South East Personnel Leasing, Inc. and subsidiaries (collectively "SPLI"), your temporary staffing employer, if any, ("Temporary Staffing Employer"), and (your "Worksite Employer"), and you will utilize binding arbitration to resolve all disputes that may arise out of the employment context. In consideration of your employment and other good and valuable consideration, including but not limited to the promises herein and the compensation and benefits paid to you, the receipt and sufficiency of which is acknowledged by the parties, the parties agree to the following terms of this Agreement.

1. "SPLI Entities" includes SPLI's past, present and future parent entities (direct or indirect), subsidiaries (direct or indirect), affiliates, legal successors, predecessors, assigns, businesses, investors, as well as the owners, directors, officers, managers, members, shareholders, principals, employees and agents of same.
2. Any dispute or claim of any kind or nature between you and SPLI, any of the applicable SPLI Entities, your Temporary Staffing Employer, or your Worksite Employer arising out of, related to, or in connection with any aspect of your employment or its termination, including but not limited to claims for breach of contract, negligence, torts, unpaid wages or other wage payment or compensation-related claims, discrimination, harassment or retaliation in violation of Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1991, 42 U.S.C. § 1981, the Age Discrimination in Employment Act of 1967, the Americans With Disabilities Act of 1990, the Family and Medical Leave Act of 1993, the Fair Labor Standards Act, the Fair Credit Reporting Act, or any other federal, state or local law, will be settled by final and binding arbitration conducted by a single, neutral arbitrator. **In agreeing to arbitrate claims, you and SPLI, the SPLI entities, your temporary staffing employer, and your worksite employer agree to waive the right to have covered disputes decided by a judge or jury.** This Agreement applies to all disputes or claims that arose before and/or after this Agreement went into effect.
3. Claims for state employment insurance benefits (e.g., unemployment compensation, workers' compensation), and any other claims that, by law, cannot be required to be resolved by binding arbitration are not covered, and thus are not subject to arbitration. In addition, this Agreement does not prevent you from filing charges with, or participating in investigations conducted by, government agencies with oversight over employment laws, including but not limited to the National Labor Relations Board and the U.S. Equal Employment Opportunity Commission. To the extent that a benefit plan specifies that a claim under the benefit plan be arbitrated under the benefit plan's arbitration process and/or procedures, then that arbitration process and/or procedures shall apply to the benefit claim.
4. The arbitration will be administered by the American Arbitration Association ("AAA") under its Employment Arbitration Rules and Mediation Procedures (including the Optional Rules for Emergency Measures of Protection), except as otherwise provided in this Agreement. These rules are available on the AAA's website located at: https://www.adr.org/.
5. Arbitration must be initiated by filing a written arbitration demand stating a description of the claim(s) and the remedy sought at any office of the AAA within the time limit established by the applicable substantive law's statute of limitations.
6. Arbitration will take place in the metropolitan area where you are or were last employed, unless prohibited by applicable law. The parties may agree to another location for the arbitration.
7. If SPLI, the SPLI Entities, your Temporary Staffing Employer, or your Worksite Employer files an arbitration claim, it will pay all arbitration fees and other forum costs charged by AAA. If you file an arbitration claim, you will pay an arbitration filing fee of $200 when the claim is filed; SPLI, the SPLI Entities, your Temporary Staffing Employer, or your Worksite Employer will pay for the remainder of the arbitration filing fees and all other arbitration forum costs charged by AAA. However, if it is determined by AAA that it would be an undue hardship on you to pay your $200 portion of the filing fee, then SPLI, the SPLI Entities, your Temporary Staffing Employer, or your Worksite Employer will pay that amount.
8. Upon a finding that a party has sustained its burden of persuasion in establishing a violation of applicable law, the arbitrator shall have the same power and authority as would a court to grant any relief, including costs and attorney's fees, in conformance with applicable principles of federal or state decisions and statutory law. The arbitrator shall issue an award in writing and state the essential findings and conclusions on which the award is based. Judgment on the award issued by the arbitrator may be entered in any court having jurisdiction.
9. The arbitrator has no authority to consolidate claims by different persons into one proceeding, nor shall the arbitrator have the power to hear an arbitration as a group, class or collective action (a group, class or collective action includes an arbitration or lawsuit where representative members of a group who claim to share a common interest seek group, class or collective relief).
10. If a party files a lawsuit in court to resolve claims subject to arbitration, the parties agree that the court shall dismiss the lawsuit and require that the claims be resolved through arbitration as provided herein.
11. **Class or collective action waiver – by entering into this agreement you and SPLI, the SPLI entities, your temporary staffing employer, and your worksite employer waive the right to commence or be party to any group, class or collective action claim (other than representative actions, separately addressed in paragraph 12 below) in arbitration or any other forum arising out of, related to, or in connection with any aspect of your employment and separation. The parties agree that any claim by or against you or SPLI, the SPLI entities, your temporary staffing employer, or your worksite employer will be heard on an individual basis without consolidation of such claim with any other person's or entity's claim. This provision is not applicable to the extent such waiver is prohibited by the law of the state in which you work. If this provision does not apply, the group, class or collective action claim must be litigated in a civil court of competent jurisdiction.**
12. **Representative action waiver – by entering into this agreement you and SPLI, the SPLI entities, your temporary staffing employer, and your worksite employer waive the right to commence or be party to any representative action claim in arbitration or any other forum arising out of, related to, or in connection with any aspect of your employment and separation. The parties agree that any claim by or against you or SPLI, the SPLI entities, your temporary staffing employer or your worksite employer will be heard on an individual basis without consolidation of such claim with any other person's or entity's claim, including participating as a named aggrieved employee plaintiff or as an aggrieved employee member of a representative action. This provision is not applicable to the extent such waiver is prohibited by the law of the state in which you work. If this provision does not apply, the representative action claim must be litigated in a civil court of competent jurisdiction.**
13. Any party may apply to the arbitrator seeking injunctive relief until the arbitration award is rendered, or the controversy is otherwise resolved. Any party also may, without waiving any remedy under this Agreement, seek from any court having jurisdiction any interim or provisional relief that is necessary to protect the rights or property of that party, pending the appointment of the arbitrator or pending the arbitrator's determination of the merits of the controversy. While it is the intent of the parties that this Agreement be fully enforced, to the extent any judicial action is required in aid of this Agreement, the parties agree that any such action will be brought exclusively in the United Stated District Court for the district in which you are or were last employed.
14. The parties expressly acknowledge and agree that this Agreement involves interstate commerce and the interpretation and enforcement of the arbitration provisions herein will be governed by the provisions of the Federal Arbitration Act, 9 U.S.C. § 1 et seq., to the exclusion of any different or inconsistent state or local law, ordinance or judicial rule.
15. New employees must sign this Agreement as a condition of employment.
16. The SPLI Entities, your Temporary Staffing Employer, and your Worksite Employer are express third-party beneficiaries of this Agreement.
17. If for any reason the provisions of this Agreement requiring arbitration of disputes are found to be invalid, unenforceable or void, then **to the fullest extent allowed by applicable law, you and SPLI, the SPLI entities, your temporary staffing employer, and your worksite employer expressly agree to waive any right to seek or demand a jury trial and agree to have any dispute decided solely by a judge of the court.**
18. Nothing in this Agreement modifies the at will nature of your employment which can be terminated at any time, with or without cause.
19. This Agreement may be modified, in whole or in part, or terminated by SPLI only after an authorized SPLI representative provides at least 14 days' written notice of the modification or termination. The Agreement in effect at the time a claim is filed by a party will govern the process by which the claim is determined.
20. This Agreement represents the entire agreement and understanding between you and SPLI, the SPLI Entities, your Temporary Staffing Employer, and your Worksite Employer regarding the subject matter covered herein. This Agreement supersedes all prior understandings and agreements between the parties on the covered subject matter.

V. ACUERDO DE ARBITRAJE - Por favor lea cuidadosamente este documento. Describe cómo se manejarán las disputas laborales, si las hay, si no se pueden resolver internamente. Al aceptar el empleo, usted acepta los términos de este Acuerdo de Arbitraje ("Acuerdo"). Usted acepta y reconoce que South East Personnel Leasing, Inc. y sus subsidiarias (colectivamente "SPLI"), su empleador de personal temporal, si lo hubiera ("Empleador de Personal Temporal") y (su "Empleador del Lugar de Trabajo"), y usted utilizaran el arbitraje obligatorio para resolver todas las disputas que puedan surgir del contexto laboral. En consideración a su empleo y otras contraprestaciones, que incluyen pero no se limitan a las promesas incluidas en este documento y la compensación y beneficios pagados a usted, cuyo recibo y suficiencia son reconocidos por las partes, las partes acuerdan los siguientes términos de este Acuerdo.

1. Las "Entidades SPLI" incluye las entidades matrices pasadas, presentes y futuras de SPLI (directa o indirectamente), subsidiarias (directas o indirectas), afiliadas, sucesores legales, predecesores, cesionarios, negocios, inversionistas, así como los propietarios, directores, funcionarios, gerentes, miembros, accionistas. , directores, empleados y agentes de la misma.
2. Cualquier disputa o reclamo de cualquier tipo o naturaleza entre usted y SPLI, cualquiera de las Entidades SPLI aplicables, su Empleador de Personal Temporal , o su Empleador del Lugar de Trabajo que surja de, relacionado con, o en conexión con cualquier aspecto de su empleo o su terminación, incluyendo pero no limitado a reclamos por incumplimiento de contrato, negligencia, agravios, salarios no pagados u otro pago de salario o reclamos relacionados con compensación, discriminación, acoso o represalias en violación del Título VII de la Ley de Derechos Civiles de 1964, los Derechos Civiles de la Ley de 1991, 42 USC § 1981, la Ley de Discriminación por Edad en el Empleo de 1967, la Ley de Estadounidenses con Discapacidades de 1990, la Ley de Permisos Medicos y Familiares de 1993, la Ley de Normas Razonables de Trabajo, la Ley de Informes Crediticios Justos o cualquier otra ley federal, estatal o local , será resuelto por arbitraje definitivo y obligatorio realizado por un solo árbitro imparcial. **Al aceptar el arbitraje de reclamos, usted y SPLI, las entidades SPLI, su empleador de personal temporal y su empleador en el lugar de trabajo acuerdan renunciar al derecho a disputas cubiertas decididas por un juez o jurado.** Este Acuerdo se aplica a todas las disputas o reclamos que surgieron antes y / o después de que este Acuerdo entró en vigencia.
3. Los reclamos para beneficios del seguro estatal de empleo (por ejemplo, compensación por desempleo, compensación laboral) y cualquier otro reclamo que, por ley, no se pueda exigir que se resuelva mediante arbitraje obligatorio, no están cubiertos, y por lo tanto no están sujetos a arbitraje. Además, este Acuerdo no le impide presentar cargos, ni participar en investigaciones conducidas por agencias gubernamentales con supervisión sobre las leyes laborales, incluyendo, entre otros, la Junta Nacional de Relaciones Laborales y la Comisión de Igualdad de Oportunidades de Empleo de EE. UU. En la medida en que un plan de beneficios especifique que un reclamo bajo el plan de beneficios sea sometido a arbitraje según el proceso y/o procedimientos de arbitraje del plan de beneficios, entonces ese proceso de arbitraje y/o procedimientos se aplicarán al reclamo de beneficios.
4. El arbitraje será administrado por la Asociación Americana de Arbitraje ("AAA") bajo sus Reglas de Arbitraje Laboral y Procedimientos de Mediación (incluyendo las Reglas Opcionales para Medidas de Protección de Emergencia), excepto que se disponga lo contrario en este Acuerdo. Estas reglas están disponibles en el sitio web de la AAA ubicado en: https://www.adr.org/.
5. El arbitraje debe iniciarse mediante la presentación de una demanda de arbitraje por escrito que establezca una descripción de la(s) demanda(s) y el remedio solicitado en cualquier oficina de la AAA dentro del plazo establecido por el estatuto de limitaciones de la ley sustantiva aplicable.
6. El arbitraje tendrá lugar en el área metropolitana en la que está o estuvo empleado por última vez, a menos que lo prohíban las leyes aplicables. Las partes pueden acordar otro lugar para el arbitraje.
7. Si SPLI, las Entidades SPLI, su Empleador de Personal Temporal o su Empleador de Lugar de Trabajo presentan un reclamo de arbitraje, pagará todas las tarifas de arbitraje y otros costos de foro cobrados por AAA. Si usted presenta un reclamo de arbitraje, usted pagará una tarifa de presentación de arbitraje de $ 200 cuando se presente el reclamo; SPLI, las Entidades SPLI, su Empleador Temporal de Personal, o su Empleador de Lugar de Trabajo pagarán por el resto de las tarifas de presentación de arbitraje y todos los demás costos de foro de arbitraje cargados por AAA. Sin embargo, si AAA determina que sería una dificultad excesiva para usted pagar su parte de la tarifa de presentación de $ 200, entonces SPLI, las Entidades SPLI, su Empleador Temporal de Personal o su Empleador de Lugar de Trabajo pagarán esa cantidad.
8. Tras concluir que una parte ha soportado su carga de persuasión al establecer una violación de la ley aplicable, el árbitro tendrá el mismo poder y autoridad que un tribunal para otorgar cualquier alivio, incluidos los costos y honorarios de abogados, de conformidad con los principios aplicables de decisiones federales o estatales y la ley estatutaria. El árbitro emitirá una sentencia por escrito e indicará los hallazgos y conclusiones esenciales en los que se basa la sentencia. El fallo sobre la sentencia emitida por el árbitro se puede ingresar en cualquier tribunal que tenga jurisdicción.
9. The El árbitro no tiene autoridad para consolidar reclamos de diferentes personas en un solo procedimiento, ni el árbitro tendrá la facultad de escuchar un arbitraje como grupo, clase o acción colectiva (un grupo, clase o acción colectiva incluye un arbitraje o demanda donde los miembros representativos de un grupo que dice compartir un interés común, busca alivio grupal, de clase o colectivo).
10. Si una de las partes presenta una demanda ante el tribunal para resolver reclamos sujetos a arbitraje, las partes acuerdan que el tribunal desestimará la demanda y exigirá que los reclamos se resuelvan mediante el arbitraje según lo dispuesto en este documento.
11. **Renuncia de acción de clase o colectiva: al celebrar este acuerdo usted y SPLI, las entidades SPLI, su empleador temporal de personal y su empleador de lugar de trabajo renuncian al derecho de comenzar o ser parte de un reclamo de accion de grupo, clase o colectiva (que no sean acciones representativas, abordadas por separado en el párrafo 12 a continuación) en arbitraje o en cualquier otro foro que surja de, relacionado con, o en conexión con, cualquier aspecto de su empleo y separación. Las partes acuerdan que cualquier reclamo por o en contra de usted o SPLI, las entidades SPLI, su empleador temporal de personal y su empleador de lugar de trabajo será escuchado de manera individual sin la consolidación de dicho reclamo con el reclamo de otra persona o entidad. Esta disposición no es aplicable en la medida en que dicha renuncia esté prohibida por la ley del estado en el cual usted trabaja. Si esta disposición no se aplica, el reclamo de grupo, clase o acción colectiva debe ser litigado en un tribunal civil de la jurisdicción competente.**
12. **Renuncia de acción representativa – al celebrar este acuerdo usted y SPLI, las entidades SPLI, su empleador temporal de personal y su empleador de lugar de trabajo renuncian al derecho de comenzar o ser parte de un reclamo de accion de grupo, clase o colectiva en arbitraje o en cualquier otro foro que surja de, relacionado con, o en conexión con, cualquier aspecto de su empleo y separación. Las partes acuerdan que cualquier reclamo por o en contra de usted o SPLI, las entidades SPLI, su empleador temporal de personal y su empleador de lugar de trabajo será escuchado de manera individual sin la consolidación de dicho reclamo con el reclamo de otra persona o entidad, incluida la participación como empleado agraviado demandante o como un empleado agraviado miembro de una acción representativa. Esta disposición no es aplicable en la medida en que dicha renuncia esté prohibida por la ley del estado en el cual usted trabaja. Si esta disposición no se aplica, el reclamo de grupo, clase o acción colectiva debe ser litigado en un tribunal civil de la jurisdicción competente.**
13. Cualquiera de las partes puede solicitar al árbitro que solicita una medida cautelar hasta que se dicte la sentencia de arbitraje, o la controversia se resuelva de otra manera. Cualquiera de las partes puede, sin renunciar a ningún recurso bajo este Acuerdo, solicitar a cualquier tribunal competente cualquier alivio provisional o interino que sea necesaria para proteger los derechos o propiedad de esa parte, en espera del nombramiento del árbitro o en espera de la determinación del árbitro de los méritos de la controversia. Si bien la intención de las partes es que este Acuerdo se cumpla por completo, en la medida en que se requiera una acción judicial en ayuda de este Acuerdo, las partes acuerdan que dicha acción se presentará exclusivamente en el Tribunal de Distrito de Estados Unidos en el distrito en el cual usted este o estuvo empleado por última vez.
14. Las partes expresamente reconocen y aceptan que este Acuerdo implica comercio interestatal y la interpretación y cumplimiento de las disposiciones de arbitraje en este documento se regirán por las disposiciones de la Ley Federal de Arbitraje, 9 U.S.C. § 1 et seq., con exclusión de cualquier ley, ordenanza o norma judicial estatal o estatal diferente o inconsistente.
15. Los nuevos empleados deben firmar este Acuerdo como una condición de empleo.
16. Las Entidades SPLI, su Empleador Temporal de Personal, o su Empleador de Lugar de Trabajo son expresamente terceros beneficiarios de este Acuerdo.
17. Si por alguna razón las disposiciones de este Acuerdo que requieren arbitraje de disputas son inválidas, inaplicables o nulas, entonces, **en la máxima medida permitida por la ley aplicable, usted, las entidades SPLI, su empleador temporal de personal, o su empleador de lugar de trabajo aceptan expresamente renunciar a cualquier derecho a solicitar o exigir un juicio con jurado y acuerdan que cualquier disputa sea decidida únicamente por un juez del tribunal**.
18. Nada en este Acuerdo modifica la naturaleza a voluntad de su empleo que puede rescindirse en cualquier momento, con o sin causa.
19. Este Acuerdo puede ser modificado, en su totalidad o en parte, o rescindido por SPLI solo después de que un representante autorizado de SPLI proporcione al menos 14 días de aviso por escrito de la modificación o terminación. El Acuerdo vigente en el momento en que un reclamo es presentado por una parte regirá el proceso por el cual se determina el reclamo.
20. Este Acuerdo representa la totalidad del acuerdo y entendimiento entre usted y SPLI, las Entidades SPLI, su Empleador Temporal de Personal y su Empleador de Lugar de Trabajo con respecto al tema tratado en este documento. Este Acuerdo reemplaza todos los convenios y acuerdos previos entre las partes sobre el tema tratado.

SPLI

By:

Its: Director, Human Resources and Benefits

I have read, or had read to me, and understand the I. APPLICANT ACKNOWLEDGEMENT, II. SAFE WORKING PRACTICES ACKNOWLEDGEMENT, III. ACKNOWLEDGMENT OF THE POST-ACCIDENT/ REASONABLE SUSPICION PROGRAM, IV. ACKNOWLEDGMENT OF ALCOHOL AND DRUG POLICY, and V. ARBITRATION AGREEMENT.

He leído, o se me ha leído, y comprendo I. RECONOCIMIENTO DEL SOLICITANTE, II. RECONOCIMIENTO DE PRACTICAS DE SEGURIDAD DE TRABAJO, III. RECONOCIMIENTO DEL PROGRAMA DE SOSPECHA RAZONABLE POSTERIOR AL ACCIDENTE, IV. RECONOCIMIENTO DE POLIZA DE ALCOHOL Y DROGA, y V. ACUERDO DE ARBITRAJE.

AGREED and ACCEPTED as of (ACORDADO y ACEPTADO a partir de)_____

Date (Fecha)

_____

Applicant's Printed Name (Nombre Impreso del Solicitante)

_____

Applicant's Signature (Firma del Solicitante)

SOUTHEAST PERSONNEL LEASING, INC.

DEDUCTION AUTHORIZATION (AUTORIZACION DE DEDUCCIÓN)

Employee Name (Nombre): _____ SSN (Número de Seguridad Social): _____

Client Name (Compañia del Cliente): _____

Benefits Deductions (Deducciones para Beneficios)

	Check One (marque uno)	Insurance Company Name or 3rd Party Administrator (Nombre de la compañía de seguros o administrador del plan)	Type of Deduction Health/Dental/401k/ Roth/Simple IRA (Tipo de Deducción)	Deduction Begin Date (Fecha de Comienzo)	Amount or Percentage per Pay Period (Cantidad por Período de Paga)		
1	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				**Pre-Tax Amount** or **Post-Tax Amount**		**Balance**, if any
2	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				**Pre-Tax Amount** or **Post-Tax Amount**		**Balance**, if any
3	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				**Pre-Tax Amount** or **Post-Tax Amount**		**Balance**, if any
4	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				**Pre-Tax Amount** or **Post-Tax Amount**		**Balance**, if any
5	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				**Pre-Tax Amount** or **Post-Tax Amount**		**Balance**, if any

***Child Support (CS) Deductions** ○ **Yes, I have CS deductions** ○ **No, I do not have CS deductions** **Initials** (Iniciales): _____

*(Deducciones de Manutención) (Sí, tengo deducciones de Manutención) (No, no tengo deducciones de Manutención

	State of Order (Estado de Orden)	Case # (Caso #)	Address for Distribution (Dirección para distribución)	Amount Per Pay Period (Cantidad por Período de Paga)
1				
2				
3				
4				
5				

***Child Support Order(s) MUST be attached** (*La orden de manutención debe estar adjunta)

Payroll Deductions ○ **Yes, I have payroll deductions** ○ **No, I do not have payroll deductions** **Initials** (Iniciales): _____

(Deducciones de Nómina) (Sí, tengo deducciones de nómina) (No, no tengo deducciones de nómina)

	Type of Deduction (Uniform, Loan, Advance, etc.) (Tipo de deduccion: **uniforme, prestamo, adelanto, etc.**)	Payroll Commencement Date (Fecha de Comienzo de Nomina)	Total Amount of Deduction (Cantidad Total De Deucción)	Amount Per Pay Period (Cantidad por Periodo de Paga)
1				
2				
3				
4				
5				

I hereby authorize SPLI to make the above deductions from my pay in accordance with the above terms. I understand and agree that I am responsible for satisfying the above amounts. I further understand and agree that deductions will be made after any federal or state requirements as well as for any SPLI or Client Company programs in which I have enrolled, for which I am eligible, or to which I have agreed. Por este medio autorizo a SPLI a hacer las susodichas deducciones de mi paga de acuerdo con los susodichos terminos. Entiendo y estoy de acuerdo que soy responsable de satisfacer las susodichas cantidades. Comprendo aún más y concuerdo que deducciones serán hechas después de cualquier exigencia federal o estatal así como para cualquier SPLI o Compañia del Cliente programas en los cuales me he matriculado, por los que soy elegible, o con que he estado de acuerdo.

Employee Signature (Firma del Solicitante): _____ **Date** (Fecha): _____

Client Signature (Firma del cliente): _____ **Date** (Fecha): _____

USE BLACK OR BLUE INK ONLY

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) _____ Division _____

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** _____

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)

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 South East Personnel Leasing, Inc.	**4. Employer Mailing Address, Telephone No. and Email Address** 2739 US HWY19 North Holiday, Florida 34691 727-938-5562	**5. Employer Identification Number (EIN)** 59-3298197
JOB APPLICANT INFORMATION		
6. Applicant Name (Last, First, MI)	**7. Social Security Number** _____ **USE BLACK OR BLUE INK ONLY**	**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 ☐

Enter **date of felony conviction** *(mm/dd/yyyy):* _____ and **release date:** _____

Federal conviction: ☐ **State conviction:** ☐ **List applicable state:** _____.

Check here if the job applicant is in a Work Release Program: ☐

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 ☐

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 the 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:**

U.S. Department of Labor
Employment and Training Administration

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

Work Opportunity Tax Credit
LONG-TERM UNEMPLOYMENT RECIPIENT (LTUR)
SELF-ATTESTATION FORM (SAF)

Instructions: The Self-Attestation Form (SAF) is to be completed, signed, and dated by the applicant / new hire, only. Employers or their authorized representatives should submit the completed SAF along with IRS Form 8850, *Pre-Screening Notice and Certification Request for the Work Opportunity Tax Credit,* or if filed separately, with ETA Form 9061/ETA Form 9062, to the State Workforce Agency (SWA) for each certification request submitted for the Long-Term Unemployment Recipient (LTUR) targeted group.

Applicant Self-Attestation: Under penalties of perjury, I declare that the information below is true and correct to the best of my knowledge. **USE BLACK OR BLUE INK ONLY**

Applicant's Full Name (Print: *First, Middle Initial, Last):* _____

Applicant's Signature: _____ **Date:** _____

Applicant's Social Security Number: _____ **Date of Birth:(mm/dd/yyyy)** _____

Employer's Name: South East Personnel Leasing

Employer's Firm/Company Name: South East Personnel Leasing

Applicant Instructions: Please check "✓" the statement below if it applies to you and fill in the requested information below.

☐ I declare that I was/am in a period of unemployment that was/is at least 27 consecutive weeks; **and,** for all or part of that unemployment period, I received unemployment compensation under State or Federal law.

State(s) unemployment compensation was received: _____.

I have been in a period of unemployment since (Enter unemployment start date: mm/dd/yyyy) _____

Privacy Act Notice:
Section 51 of the Internal Revenue Code of 1986, as amended, and its enacting legislation (P.L. 104-188), specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification process. The information you have provided by completing this Form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however, the information is required to determine your employer's eligibility for the federal work opportunity tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this Form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. Send comments Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Act – OMB Control No. 1205-0371). Please do not submit completed WOTC processing forms to this address.