

INSTRUCTIONS FOR COMPLETING APPLICATION PACKET

****NOTE-WHEN RETURNING APPLICATION FEDERAL LAW REQUIRES THAT YOU BRING IDENTIFICATION TO PROVE YOUR ELIGIBILITY TO WORK IN THE UNITED STATES. APPLICATIONS WILL NOT BE PROCESSED WITHOUT THIS PROOF**** Commonly used forms are state-issued ID or driver's license, plus Social Security card or state-issued Birth Certificate. Refer to back of I-9 form enclosed in packet.

PAGES 1 & 2.....INFORMATIONAL TRI-FOLD – READ CAREFULLY

PAGE 3.....ASSOCIATE INFORMATION PACKET – READ AND SIGN

PAGE 4.....AVAILABILITY STATEMENT – READ AND SIGN, PRINT, AND DATE

PAGES 5 & 6.....I-9
COMPLETE SECTION 1, SIGN AND DATE.

PAGES 7 & 8.....SEDONA APPLICATION
FRONT: TOP SECTION TO SOLID BLACK LINE, SIGN AND DATE
BACK: CHECK ALL WORK AREAS YOU HAVE EXPERIENCE
IN AND WOULD LIKE TO BE CONSIDERED FOR

PAGES 9 & 10.....FEDERAL W-4
FILL OUT BOTTOM SECTION (BELOW DOTTED LINE), SIGN AND DATE

PAGES 11 & 12.....STATE W-4
FILL OUT BOTTOM SECTION (BELOW DOTTED LINE), SIGN AND DATE

PAGE 13.....AUTHORIZATION TO MAIL PAYCHECK – READ CAREFULLY, SELECT
MAIL CHECK OR HOLD CHECK, SIGN AND DATE

PAGE 14.....EMPLOYEE ACKNOWLEDGEMENT & CONSENT FORM
READ CAREFULLY. SIGN, PRINT NAME AND DATE

PAGE 15.....NOTIFICATION OF BACKGROUND INVESTIGATION
READ CAREFULLY. SIGN AND DATE

PAGE 16.....VIOLENCE IN THE WORKPLACE
READ CAREFULLY. SIGN AND DATE.

PAGES 17-24.....INSURANCE/BENEFITS FORM
FILL OUT TOP SECTION AND CHECK THE INSURANCE YOU REQUIRE,
OR CHECK THE “NO” BOX IF INSURANCE IS NOT NEEDED.

****SIGNATURE REQUIRED ON ALL FORMS****

Sedona Staffing Services Benefit Plan

One-Week (five-day) Paid Bonus: Eligible after 1500 career hours within an 18-month period. Bonus is based on average of past 1500 hours wage.

Health Insurance: Associates are eligible upon placement for **employee-paid** health, supplement and dental insurance.

Referral Bonuses: The person you refer must work a minimum number of hours. Referral bonus slips must be filled out prior to having new associates register with Sedona Staffing Services.

Direct Deposit: Available with any financial institution. Eligible after 40 career hours.

Software Training: Free to anyone registered with Sedona Staffing Services.

Family Leave and Medical Act: Eligible if worked for Sedona Staffing Services for a total of 12 months (need not be consecutive) and have worked at least 1,250 hours during the 12-month period immediately prior to the beginning of the leave.

401K Retirement Package: Eligible after 400 career hours.

Office Services: Free photocopies (within reason) and faxes within USA.

Requirements for the eligibility of benefits and incentives may vary depending on the benefit package offered by Sedona for specific clients.

Tri-fold DBQ Rev. 1/1/10

Harassment: Any type of harassment is not only forbidden, it is against the law. This includes sexual and non-sexual harassment. If you feel that you are a victim of any type of harassment, report it immediately to the Sedona Staffing Services office or call Nikki Kiefer at 563-556-3040 and Sedona Staffing Services will investigate the matter immediately.

Sexual harassment is defined as unwelcome sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature when:

- Submission to the harassment is made a condition of keeping his/her job. Employment decisions are based on submission or rejection of sexual advances.

- The harassment has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment.

To help you gain a better understanding of what constitutes harassment, here are some examples:

MAY BE SEXUAL HARASSMENT

- Remarks with obvious sexual overtones
- Continuous, or constant staring
- Repeated, rejected invitations
- Unwelcome, familiar physical contact
- Repeated, unwelcome comments

MAY NOT BE SEXUAL HARASSMENT

- Social invitations advanced on the job
- A complimentary remark on the job
- Occasional glances

Non-Sexual Harassment because of a person's gender, race, or membership in any other protected category is unlawful – even if there is no “sexual” content to the harassing conduct.

This is not an employee contract. Nor is it an implied contract. Employment is at will.



**3392 Hillcrest Road
Dubuque, Iowa 52002**

**Phone (563) 556-3040
Fax (563) 556-3041**

www.careerpros.com

Sedona Staffing Services is an
Equal Opportunity Employer

Specializing in:

- Temporary Placements
- Temporary-To-Hire Placements
- Direct Hire Placements

Office Hours:

**Monday – Friday
8:00 a.m. – 5:00 p.m.
24 hour answering service**

Availability

Once you have completed the application process with Sedona Staffing Services, you are entered into our employee database. Initially, your status is listed as Available. If at anytime you notify us that you no longer need our services, you will be listed as Inactive. Should that status ever change you only need to call our office and we will update and reactivate your file.

Beginning an Assignment

We are pleased to have you as a part of the Sedona team. We have set a high standard of service for our clients and as a Sedona representative, we expect you to be professional and do the very best you can to fulfill the client's needs. Please learn the company rules where you are assigned, such as smoking policy, personal phone use, lunch hours, breaks, etc. Confidentiality is of utmost importance. That includes confidentiality of any information you learn about a company while on an assignment and confidentiality regarding your pay. *Prior to the beginning of the assignment we will make sure you know where to go, who to report to, what to wear, where to park, and what will be expected of you.*

Dress Code

- Your attire will depend on where you are working. If you are uncertain, please ask.

Absenteeism

- Dependability and being on time for assignments is very important. If you must miss or be late for work, you must notify our office and/or follow client/Sedona specific directions as early as possible prior to the start time: during office hours at 563-556-3040 or if after office hours at 563-556-3040 ext. 216.
- Dependability is very important. Failure to report to an assignment, walking off the job or failure to notify us in a timely manner could be documented as a voluntary quit from Sedona Staffing Services.

Injuries & Safety Regulations...

- Please follow all safety rules and regulations while working on an assignment. If you are asked to do work other than described, inform our office as soon as possible.
- Wear all personal protective equipment required for an assignment.
- Report any unsafe or potential hazardous conditions to your supervisor and our office immediately.
- **If you are injured while on assignment, you must notify your supervisor and our office immediately.**
- Should you require medical treatment for a work-related injury, you will be sent to our health care provider: Tri-State Occupational Health at 1940 Elm Street.
- After any work injury you need to complete an accident report at our office within 24 hours regardless of whether or not you seek medical treatment. A drug screen will be required when medical treatment is necessary.

Getting paid...

Time reporting is your responsibility. Follow exact time reporting method from account manager at time of placement. If turning in timecards, make sure they are properly filled out and signed each week that you work. Keep the following in mind:

- Each timecard is required to be signed by your supervisor as well as yourself.
- **The deadline for returning the white copy to our office is by 10:00 A.M. Monday following your workweek.** Failure to submit your timecard by the deadline may cause the check to be delayed until the following week.
- You may turn in your timecard during office hours, deposit it in the drop box outside our office, or fax a copy to 563-556-3041. Call our office to confirm we have received your faxed copy.

Paychecks...

Paychecks are available on Friday following the week you work. You may pick up your check at our office from 7:00 a.m. until 4:00 p.m. unless otherwise noted. If you do not pick up your check by 4:00 p.m. on Friday, we will mail your check to you. Prior arrangements need to be made for the following options for receiving your check: hold, mail it, or direct deposit (we encourage). Iowa Wage Law requires a signed request form on file with Sedona. Someone else may pick your check up with prior written authorization from you, (you must complete our authorization form prior to payday).

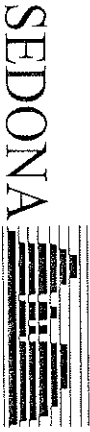
Checking in for work...ext. 216

We want to stay in touch with you. To let us know of your availability, please call 563-556-3040 ext. 216.

- Leave your full name, telephone number, and type of employment. Please speak clearly.
- Upon completion of each assignment, you must contact Sedona Staffing Services within three (3) working days to request a new assignment. If a claim for unemployment is filed, failure to contact Sedona Staffing Services may affect your benefit eligibility.

Give Us A Call When...

- The completion date of your assignment changes.
- You have questions about your timecard.
- You are requested back by the client or are offered a position by the client.
- Your duties are different than what was explained to you by Sedona Staffing Services.
- The client asks you to work overtime or if your work assignments total more than 40 hours in one week.
- You have any changes in your address or phone number.
- Your status for availability or employment has changed.



Associate Information Packet

Associate Information Packet

I acknowledge that I have received and read the Associate Information Packet.

I fully understand the information regarding Rules & Regulations, Safety & Injuries and Benefits; and I understand my role in complying with these policies. I understand that the policies included in this packet do not constitute a contract of employment, and are subject to unilateral change by Sedona Staffing Services from time to time.

Associate's Name Printed

Associate's Signature

Date

Sedona Representative's Signature
RG11 (Rev 1/03)

Availability Statement

According to the policies of Sedona Staffing Services, an employee must, upon completion of an assignment, contact Sedona Staffing Services, and request placement on a new assignment. If such contact is not made within three working days of completion of the last assignment, Sedona Staffing will consider the employee to have voluntarily quit employment and further assignments may not be offered. In addition, if a claim for unemployment benefits is filed, failure to contact Sedona Staffing may affect the employee's benefit eligibility.

Associate's Signature: _____ Date: _____

Print name: _____

Sedona Representative's Signature: _____ Date: _____

Print name: _____

Copy: White/Office --- Yellow Associate

RG13 Availability Stmt

Availability Statement

According to the policies of Sedona Staffing Services, an employee must, upon completion of an assignment, contact Sedona Staffing Services, and request placement on a new assignment. If such contact is not made within three working days of completion of the last assignment, Sedona Staffing will consider the employee to have voluntarily quit employment and further assignments may not be offered. In addition, if a claim for unemployment benefits is filed, failure to contact Sedona Staffing may affect the employee's benefit eligibility.

Associate's Signature: _____ Date: _____

Print name: _____

Sedona Representative's Signature: _____ Date: _____

Print name: _____

Copy: White/Office --- Yellow Associate

RG13 Availability Stmt

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

Form I-9, Employment Eligibility Verification

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

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

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

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

<p>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.</p>	<p>I attest, under penalty of perjury, that I am (check one of the following):</p> <p><input type="checkbox"/> A citizen of the United States</p> <p><input type="checkbox"/> A noncitizen national of the United States (see instructions)</p> <p><input type="checkbox"/> A lawful permanent resident (Alien #) _____</p> <p><input type="checkbox"/> An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)</p>
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Employee's Signature _____ Date *(month/day/year)* _____

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

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

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

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

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

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address <i>(Street Name and Number, City, State, Zip Code)</i>		Date <i>(month/day/year)</i>
Sedona Staffing Services 3392 Hillcrest Rd Dubuque, IA 52002		

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

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

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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

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

All documents must be unexpired

LIST A
Documents that Establish Both
Identity and Employment
Authorization

LIST B
Documents that Establish
Identity

LIST C
Documents that Establish
Employment Authorization

OR

AND

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

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

EMPLOYMENT APPLICATION

We consider applicants for all positions without regard to age, race, color, religion, sex, national origin, marital or veteran status, the presence of non-job related medical condition or disability, or any other legally protected status.

SOCIAL SECURITY #	LAST NAME	FIRST	MIDDLE	APPLICATION DATE
ADDRESS	CITY	STATE	ZIP	HOME PHONE #
CIRCLE DAYS AVAILABLE FOR ASSIGNMENT: M T W TR F SA SU		EMAIL ADDRESS:	TRANSPORTATION	HOW DID YOU HEAR OF SEDONA?
WHOM SHOULD WE NOTIFY IN CASE OF EMERGENCY?			PHONE:	ARE YOU OVER 18 YRS OLD?
WHAT OTHER TEMPORARY SERVICES HAVE YOU WORKED FOR:			ARE YOU LEGALLY AUTHORIZED TO WORK IN THE U.S.?	

HAVE YOU BEEN CONVICTED OF A FELONY IN THE LAST SEVEN YEARS? (WILL NOT NECESSARILY DISQUALIFY APPLICANT FROM EMPLOYMENT.)

CIRCLE HIGHEST LEVEL OF EDUCATION COMPLETED: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	NAME OF HIGHEST SCHOOL ATTENDED:	CITY	STATE	DEGREE	MAJOR OR TYPE COURSE
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WORK HISTORY - LIST CURRENT OR MOST RECENT

EMPLOYER #1 _____ CITY _____ STATE _____ PHONE _____

JOB TITLE _____ SUPERVISORS NAME _____

START DATE _____ END DATE _____ PAY RATE _____ REASON FOR LEAVING _____ MAY WE CONTACT? _____

EMPLOYER #2 _____ CITY _____ STATE _____ PHONE _____

JOB TITLE _____ SUPERVISORS NAME _____

START DATE _____ END DATE _____ PAY RATE _____ REASON FOR LEAVING _____ MAY WE CONTACT? _____

EMPLOYER #3 _____ CITY _____ STATE _____ PHONE _____

JOB TITLE _____ SUPERVISORS NAME _____

START DATE _____ END DATE _____ PAY RATE _____ REASON FOR LEAVING _____ MAY WE CONTACT? _____

EMPLOYMENT AGREEMENT: I certify that the above information is true and correct. If employed, any misstatement or omission of fact on this application may result in my dismissal. I understand the term of my employment with this service shall be limited to the duration of any temporary assignment. I authorize Sedona Staffing Services to inquire of and receive information from my employers or personal references as to my character and ability, and I agree to hold Sedona Staffing Services and my former employers harmless from any claims resulting from transmittal, receipt, or use of this information. If injured on the job, I agree to contact my supervisor and Sedona Staffing Services immediately. I understand that Sedona Staffing Services may conduct an investigation of my credit record and/or may seek information concerning criminal conviction records from appropriate government agencies and I consent to such investigations.

EMPLOYEE SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE. PLEASE COMPLETE BACK OF THIS PAGE

TO BE COMPLETED BY SEDONA: SEARCH WORDS: _____ STATUS: P C I

INTERVIEWER: _____ R: 1 2 3 4 5 AVAILABILITY: PT TTH TEMP BOTH

DATE AVAILABLE: _____ A: 1 2 3 4 5 COMMENTS: _____

10 KEY _____ T: 1 2 3 4 5

TYPING _____ E: 1 2 3 4 5

ALPHA/NUM _____ S: 1 2 3 4 5

COMPANIES SUGGESTED: _____

RESUME: YES NO

LIFTING: 0 L M H

FACTORY GENOFF ENGNR

GENLBR EXESEC PRGRMR MANAGE BKKEEP

CUST DATAEN TECH SALREP HOME

Background checks _____ IA _____ WI _____ IL _____ File _____

Check ✓ "On the job" experience; Put an S for any "School experience"

AVAILABLE: 1st SHIFT _____ 2nd SHIFT _____ 3rd SHIFT _____
 Part-Time Only _____ Weekends ONLY _____

WAREHOUSE

- _____ Assembly line work
- _____ Electronic assembly
- _____ Forklift - experience
- _____ Forklift - Currently Certified
- _____ Foreman/ Supervisor
- _____ Inspection
- _____ ISO 9000
- _____ Quality Control/ Assurance
- _____ Inventory / Stock
- _____ Pick / Pack
- _____ Shipping & Receiving
- _____ Plant/ Machine Maintenance (not janitorial /housekeeping)

MACHINE SHOP

- _____ Machine Operator (List Types)
- _____
- _____
- _____ Metal Fabrication
- _____ Can do own set-ups
- _____ Can read blue prints
- _____ Tool & die maker
- _____ Have used measuring tools
- _____ C N C
- _____ Drafting

CARPENTRY

- _____ Contractor
- _____ Carpentry
- _____ Power tools
- _____ Roofer
- _____ Painter
- _____ Landscape or Lawn care

WELDER (circle)

- _____ Mig, Tig, Oxy, Arc
- _____ 1 yr. or less
- _____ 1 yr. or more

ELECTRICAL (circle)

- _____ Certified, Journeyman, Helper
- _____ 1 yr. or less
- _____ 1 yr. or more

PRINTING

- _____ Bindery
- _____ Print press operator

MECHANIC

- _____ Certified Mechanic
- _____ Diesel
- _____ Hobby
- _____ Small Engine/ Mechanic
- _____ Auto body work
- _____ Has own tools

DRIVER

- _____ CDL A Certified
- _____ CDL B Certified
- _____ Delivery

MISC.

- _____ Industrial Sewing
- _____ Seamstress

CUSTOMER SERVICE

- _____ Inside Salesperson
- _____ Outside Salesperson
- _____ Telemarketing
- _____ Bartender
- _____ Chef / Line Cook / Prep Cook
- _____ Fast Food
- _____ Dishwasher / bussing
- _____ Wait staff / host
- _____ Janitorial / housekeeping
- _____ Front desk clerk
- _____ Night auditor
- _____ Cashier

ACCOUNTING

- _____ Accounting degree (2 yr)
- _____ Accounting degree (4 yr)
- _____ CPA
- _____ Bookkeeper
- _____ 10-key operator
- _____ Accounts Payable > 1yr
- _____ Accounts Receivable > 1 yr
- _____ Payroll
- _____ Posting
- _____ Tax Preparation

BANKING

- _____ Finance degree
- _____ Loan or commercial mgmt
- _____ Loan processor / any
- _____ Bank officer
- _____ Proof operator
- _____ Teller

MEDICAL

- _____ Claims & codes
- _____ RN or LPN
- _____ Transcriptionist
- _____ Medical terminology

CLERICAL SKILLS

- _____ Customer service
- _____ Office manager
- _____ Receptionist / phone systems
- _____ Switchboard / computerized
- _____ Data entry - alpha/numeric
- _____ Key punch operator
- _____ Dictaphone
- _____ General secretary
- _____ Executive secretary
- _____ Legal secretary
- _____ Shorthand

OTHER

- _____ Management >1 yr
- _____ Marketing > 1yr
- _____ Public Relations > 1yr
- _____ Human Resources > 1yr
- _____ Government > 1yr
- _____ Agriculture / farming > 1yr
- _____ Teacher
- _____ Bilingual

COMPUTER/ TECHNICAL

- _____ IBM
- _____ MAC
- _____ Microsoft Word
- _____ WordPerfect
- _____ AmiPro
- _____ Windows 98
- _____ AS 400
- _____ Office 97
- _____ Excel
- _____ Access
- _____ PowerPoint
- _____ Desktop Publishing
- _____ PageMaker
- _____ Quark
- _____ Adobe Illustrator
- _____ Peachtree
- _____ Quick Books
- _____ Quicken
- _____ MAS 90
- _____ Internet
- _____ Email
- _____ Auto CAD
- _____ Pro-E
- _____ Cobol
- _____ C++ (list versions)
- _____
- _____ Java
- _____ HTML

Do you have any other skills that we should be aware of? (Please list)

Form W-4 (2012)

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 2012 expires February 18, 2013. 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 \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

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 Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 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 tax for 2012. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at www.irs.gov/w4. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

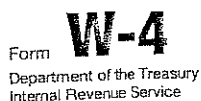
Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u> </u>
B	Enter "1" if: { <ul style="list-style-type: none"> • 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	<u> </u>
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	<u> </u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	<u> </u>
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child 	G	<u> </u>
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	<u> </u>

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.



Employee's Withholding Allowance Certificate

OMB No. 1545-0074

2012

▶ 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.

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5 <u> </u>	
6 Additional amount, if any, you want withheld from each paycheck	6 \$ <u> </u>	
7 I claim exemption from withholding for 2012, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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 <u> </u>		
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)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____			
2	Enter: <table style="display: inline-table; vertical-align: middle; border-left: 1px solid black; border-right: 1px solid black; border-collapse: collapse;"> <tr> <td style="padding: 0 5px;">\$11,900 if married filing jointly or qualifying widow(er)</td> </tr> <tr> <td style="padding: 0 5px;">\$8,700 if head of household</td> </tr> <tr> <td style="padding: 0 5px;">\$5,950 if single or married filing separately</td> </tr> </table>	\$11,900 if married filing jointly or qualifying widow(er)	\$8,700 if head of household	\$5,950 if single or married filing separately	2	\$ _____
\$11,900 if married filing jointly or qualifying widow(er)						
\$8,700 if head of household						
\$5,950 if single or married filing separately						
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$ _____			
4	Enter an estimate of your 2012 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$ _____			
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2012 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____			
6	Enter an estimate of your 2012 nonwage income (such as dividends or interest)	6	\$ _____			
7	Subtract line 6 from line 5. If zero or less, enter "-0-"	7	\$ _____			
8	Divide the amount on line 7 by \$3,800 and enter the result here. Drop any fraction	8	_____			
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9	_____			
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	_____			

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

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

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3"	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____

Note. If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$8,000	0	\$0 - \$70,000	\$570	\$0 - \$35,000	\$570
5,001 - 12,000	1	8,001 - 15,000	1	70,001 - 125,000	950	35,001 - 90,000	950
12,001 - 22,000	2	15,001 - 25,000	2	125,001 - 190,000	1,060	90,001 - 170,000	1,060
22,001 - 25,000	3	25,001 - 30,000	3	190,001 - 340,000	1,250	170,001 - 375,000	1,250
25,001 - 30,000	4	30,001 - 40,000	4	340,001 and over	1,330	375,001 and over	1,330
30,001 - 40,000	5	40,001 - 50,000	5				
40,001 - 48,000	6	50,001 - 65,000	6				
48,001 - 55,000	7	65,001 - 80,000	7				
55,001 - 65,000	8	80,001 - 95,000	8				
65,001 - 72,000	9	95,001 - 120,000	9				
72,001 - 85,000	10	120,001 and over	10				
85,001 - 97,000	11						
97,001 - 110,000	12						
110,001 - 120,000	13						
120,001 - 135,000	14						
135,001 and over	15						

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

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

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

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

Centralized Employee Registry Reporting Form

TO BE COMPLETED BY THE EMPLOYER
within 15 days of hire. Please Print or Type.

Submit this information online at
www.iowachildsupport.gov
...or mail this portion of the page to Centralized Employee
Registry, PO Box 10322, Des Moines IA 50306-0322; or fax
to 1-800-759-5881.

EMPLOYER INFORMATION

FEIN Required

Telephone Number: () - -

FEIN grid: | | | | | | | | | | | | | | | | | | | | | |

FEIN plus last 3-digit suffix used when filing Iowa withholding tax.

Name: _____

Address: _____

City: _____ State: | | | | ZIP: | | | | | | - | | | | | |

Questions: For A through D below, please see instructions on back for definitions and clarification.

A. Is dependent health care coverage available? Yes or No

B. Approximate date this employee qualifies for coverage: MM DD YYYY

C. Employee start date: MM DD YYYY

D. Address where income withholding and garnishment orders should be sent, if different than above address.

Address: _____

City: _____ State: | | | | ZIP: | | | | | | - | | | | | |

EMPLOYEE INFORMATION

Employee's Date of Birth: MM DD YYYY Employee's Social Security Number: | | | | - | | | | - | | | | | |

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

Address: _____

City: _____ State: _____ ZIP: _____



Iowa Department of Revenue
www.iowa.gov/tax

2012 IA W-4

Employee Withholding Allowance Certificate

To be completed by the employee

Marital status: Single Married (If married but legally separated, check Single.)

Print your full name _____ Social Security Number: _____

Home Address: _____ City: _____ State: _____ ZIP: _____

EXEMPTION FROM WITHHOLDING. If you do not expect to owe any Iowa income tax this year, and expect to have a right to a full refund of ALL income tax withheld, enter "EXEMPT" here: _____ and the year effective here: _____ **Nonresidents may not claim this exemption.**

Check this box if you are claiming exemption from Iowa tax based on the Military Spouses Residency Relief Act of 2009.

If claiming the military spouse exemption, enter your state of domicile here: _____

IF YOU ARE NOT EXEMPT, COMPLETE THE FOLLOWING:

1. Personal allowances 1. _____
2. Allowances for dependents 2. _____
3. Allowances for itemized deductions 3. _____
4. Allowances for adjustments to income 4. _____
5. Allowances for child and dependent care credit 5. _____
6. Total allowances. Add lines 1 through 5. 6. _____
7. Additional amount, if any, you want deducted each pay period 7. _____

I certify that I am entitled to the number of withholding allowances claimed on this certificate, or if claiming an exemption from withholding, that I am entitled to claim the exempt status.

Employee Signature: _____

Date: _____

Employers: Detach this part and keep in your records unless more than 22 withholding allowances are claimed. If more than 22 allowances are claimed, complete the section below and send it to the Iowa Department of Revenue. See Employer Withholding Requirements on the back of this form.

Employer's name / address: _____

FEIN: _____

TOP PORTION OF FORM- CENTRALIZED EMPLOYEE REGISTRY REPORTING FORM – EMPLOYER REPORTING REQUIREMENTS

An employer doing business in Iowa who hires or rehires an employee **must** complete this section. Submit online at www.iowachildsupport.gov. You may also mail this portion of the page to Centralized Employee Registry, PO Box 10322, Des Moines IA 50306-0322; or fax it to 1-800-759-5881. Please include your FEIN. **If you have questions about employer reporting requirements, call the Employers Partnering in Child Support (EPICS) Unit at 1-877-274-2580.**

Questions A through D

- A.** Is a family health insurance plan offered through employment? This question does not relate to insurability of employee's dependents.
- B.** Example: Is dependent insurance coverage offered upon hire or after six months of employment? This question does not relate to insurability of employee's dependents.
- C.** Indicate the first day for which the employee is owed compensation.
- D.** This information is needed for income withholding and garnishment purposes.

BOTTOM PORTION OF FORM – IA W-4 INSTRUCTIONS (January 1, 2012) – EMPLOYEE WITHHOLDING ALLOWANCE CERTIFICATE

Exemption from Withholding: You should claim exemption from withholding if you are a resident of Iowa and do not expect to owe any Iowa income tax or expect to have a right to a refund of all income tax withheld. If you qualify, write "EXEMPT" and the year exempt status is effective. Exempt guidelines are: (1) You are exempt if you will earn \$5,000 or less and are claimed as a dependent on another person's return, or (2) You are exempt if you will earn \$9,000 or less and are not claimed as a dependent on another person's return, or (3) married and both spouses' total is less than \$13,500. See your payroll officer to determine how much you expect to make in a calendar year. **Nonresidents may not claim this exemption.**

Under the Military Spouses Residency Relief Act of 2009, you may be exempt from Iowa income tax on your wages if (1) your spouse is a member of the armed forces present in Iowa in compliance with military orders; (2) you are present in Iowa solely to be with your spouse; and (3) you maintain your domicile in another state. If you claim this exemption, check the appropriate box, enter the state other than Iowa you are claiming as your state of domicile, and attach a copy of your spousal military identification card to the IA W-4 provided to your employer.

Taxpayers 65 years of age or older: You are exempt if you are single and your income is \$24,000 or less or if you are married and your combined income is \$32,000 or less. Only one spouse must be 65 or older to qualify for the exemption.

You must complete a new W-4 within 10 days from the day you anticipate you will incur an Iowa income tax liability for the calendar year (or your fiscal year) or on or before December 31 if you anticipate you will incur an Iowa income tax liability for the following year. If you want to claim an exemption from withholding next year, you must file a new W-4 with your employer on or before February 15.

FILING REQUIREMENTS/NUMBER OF ALLOWANCES

Each employee must file this Iowa W-4 with his/her employer. Do not claim more allowances than necessary or you will not have enough tax withheld.

- 1. Personal Allowances:** You can claim the following personal allowances:
 - 1 allowance for yourself or 2 allowances if you are unmarried and eligible to claim head of household status, plus 1 allowance if you are 65 or older, and plus 1 allowance if you are blind.
 - If you are married and your spouse either does not work or is not claiming his/her allowances on a separate W-4, you may also claim the following allowances: 1 for your spouse, plus 1 if your spouse is 65 or older, and plus 1 if your spouse is blind.
 - If you are single and hold more than one job, you may not claim the same allowances with more than one employer at the same time. If you are married and both you and your spouse are employed, you may not both claim the same allowances with both of your employers at the same time.
 - To have the highest amount of tax withheld, claim "0" allowances on line 1.
- 2. Allowances for Dependents:** You may claim 1 allowance for each dependent you will be able to claim on your Iowa income tax return.

3. Allowances for Itemized Deductions

- (a) Enter total amount of estimated itemized deductions (a) \$ _____
- (b) Enter amount of your standard deduction using the following information (b) \$ _____
 If single, married filing separately on a combined return, or married filing separate returns, enter \$1,860
 If married filing a joint return, unmarried head of household, or qualifying widow(er), enter \$4,590
- (c) Subtract line (b) from line (a) and enter the difference or zero, whichever is greater (c) \$ _____
- (d) Additional allowance: Divide the amount on line (c) by \$600, round to the nearest whole number and enter on line 3 of the IA W-4 on other side.

4. Allowances for Adjustments to Income: Estimate allowable adjustments to income for payments to an IRA, Keogh, or SEP; penalty on early withdrawal of savings; alimony paid; moving expense deduction from federal form 3903; and student loan interest, which are reflected on the Iowa 1040 form. Divide this amount by \$600, round to the nearest whole number, and enter on line 4 of the IA W-4.

5. Allowances for Child/Dependent Care Credit: Persons having child/dependent care expenses qualifying for the federal and Iowa Child and Dependent Care Credit may claim additional Iowa withholding allowances based on their net incomes. If you have qualifying child and dependent care expenses and wish to reduce your Iowa withholding on the basis of this credit, you may claim additional withholding allowances for Iowa based on the following table. Married persons, regardless of their expected Iowa filing status, must calculate their withholding allowances based on their combined net incomes. Note that if net income is \$45,000 or more, no withholding allowances are allowed for the Child and Dependent Care Credit, as taxpayers with these incomes are not eligible for the Iowa Child and Dependent Care Credit.

Withholding Allowances Allowed: Iowa Net Income Allowances	Iowa Net Income Allowances	Iowa Net Income Allowances
\$0 - \$20,000	5	\$20,000- \$30,000
		4
		\$30,000 - \$44,999
		3

Enter the number of allowances on line 5 of the IA W-4 on the reverse side. If you are married and both you and your spouse are employed, the total allowances for child and dependent care that you and your spouse may claim cannot exceed the total allowances shown above.

- 6. Total:** Enter total of lines 1 through 5.
- 7. Additional Amount of Withholding Deducted:** If you are not having enough tax withheld, you may request your employer to withhold more by filling in an additional amount on line 7. Often married couples, both of whom are working, and persons with two or more jobs need to have additional tax withheld. You may also need to have additional tax withheld because you have income other than wages, such as interest and dividends, capital gain, rents, alimony received, etc. Estimate the amount you will be under-withheld, and divide that amount by the number of pay periods per year. If you reside in a school district that imposes a school district surtax, consider reducing the amount of allowances shown on lines 1-5 or have additional tax withheld on line 7.

Changes in Allowances: You may file a new W-4 at any time if the number of your allowances INCREASES. You must file a new W-4 within 10 days if the number of allowances previously claimed by you DECREASES.

Penalties: Penalties apply for willfully supplying false information or for willful failure to supply information which would reduce the withholding allowances. If you file as exempt from withholding and you incur an income tax liability, you may be subject to a penalty for underpayment of estimated tax.

Employer Withholding Requirements: The employer must maintain records of the W-4s. If the employee is claiming more than 22 withholding allowances or is claiming exemption from withholding when wages are expected to exceed \$200 per week, the employer must send a copy of the W-4 under separate cover within 90 days to the Individual Unit, Examination Section, Iowa Department of Revenue, P.O. Box 10456, Des Moines, Iowa 50306-0456.

Questions about Iowa taxes: Call 515-281-3114 or 1-800-367-3388 from Iowa, Rock Island, Moline, Omaha, or e-mail idr@iowa.gov

SEDONA
STAFFING SERVICES

AUTHORIZATION TO MAIL PAYCHECK

I, _____, voluntarily authorize Sedona Staffing Services
(Print Name)

to forward my paycheck by U.S. mail. I understand that without written authorization, Sedona Staffing will no longer be able to forward my paycheck by mail. I further understand that this authorization may be revoked at any time, and for any time period, with written notice to Sedona Staffing Services.

- I authorize Sedona Staffing to mail my check weekly should I not pick up during check availability.
- DO NOT mail my check. I will be responsible for picking up my check at Sedona Staffing Services at the Dubuque office.

Signature

Date

ASSOCIATE ACKNOWLEDGMENT, CONSENT AND ENROLLMENT FORM

DRUG SCREEN AUTHORIZATION & CONSENT: I hereby authorize and give permission to have my employer or their agent, including their medical provider test me for the presence of alcohol and/or illegal substances, including: amphetamines, barbiturates, benzodiazepines, cocaine metabolite, opiates, phencyclidine, methadone, methaqualone, propoxyphene, THC (marijuana), or for prescription medication taken without a prescription, for any of the following reasons; pre-employment, random, and/or for cause.

I will hold my employer or their agents working on their behalf harmless, meaning I will not sue nor hold responsible for any alleged harm to me or interfering with my obtaining a job or continuing employment due to not submitting to the tests or as a result of report of the test. This includes, but is not limited to, possible clerical or laboratory error.

This policy and authorization has been explained to me in a language I understand and any questions answered. I understand this is a legal and binding document. I understand, in the event I am sent for the examination, it is per my employer's standard policy and I have no obligation for payment.

I understand it is not the policy of my employer to provide rehabilitation, but they will provide information on public rehabilitation programs or private services at my own expense if requested.

I UNDERSTAND AND GRANT MY EMPLOYER PERMISSION TO REQUIRE I SUBMIT TO A DRUG / ALCOHOL TEST FOR ANY REASON PERMITTED BY LAW, INCLUDING THE EVENT I AM INVOLVED IN AN ON THE JOB ACCIDENT, OR ANY INJURY OCCURS AT WORK, IN ACCORDANCE WITH THEIR POLICY AND THIS AUTHORIZATION AND CONSENT. MY REFUSAL TO SUBMIT TO SUCH A TEST, A POSITIVE RESULT, OR MY ADMISSION OF ALCOHOL OR ILLEGAL DRUG USE WILL BE GROUNDS FOR TERMINATION. If I, as an employee, sustain an injury during my shift as a result of my work, I will: 1) submit to a drug/alcohol test as part of my initial medical treatment, 2) go to a medical facility designated by my employer whereas, test results and expenses will go directly to my employer, 3) if employed in a directed state, I will incur all expenses if I choose to go to my own physician, 4) be considered self-terminated from my employment if I test positive for alcohol or use of an illegal drug, refuse to take the drug/alcohol test; or 5) render a prescription prescribed for myself if found to be using a legal drug, failure to do so will result in self-termination of my employment.

RELEASE OF CRIMINAL RECORDS: I, the undersigned do hereby authorize my employer, or agents working on their behalf, to examine any and all criminal records on file in the counties and states they request. I understand information found will only be considered if it is relevant to the type of work for which I am being considered.

RELEASE OF MEDICAL RECORDS: In the event I sustain a work related injury, this authorizes any physician, hospital, medical carrier or others to furnish my employer, or anyone designated in writing by them, all records, opinions, reports, x-rays, Photostat copies, abstracts or excerpts of any records or any other information or documents that they may request that you may have in your custody or under your control regarding the patient whose name is captioned above. I waive any privilege I have to said information. A Photostat or facsimile copy of this waiver of medical information signed by my employer shall have the same force and effect as the original hereof.

MODIFIED DUTY: Beginning the first day of payable loss time, following the state specified waiting period, modified duty may be provided that conforms with any restrictions imposed by the doctor. I will report for such modified duty as instructed and will remain on that assignment unless I arrange time off for doctor's visit or for treatment of the work related injury. Failure to report for modified duty or failure to report for scheduled doctor's appointments will result in my self-termination.

AVAILABILITY: I understand that in order to be considered available for work, I must notify Sedona Staffing Services daily. I understand I must contact my employer, Sedona Staffing Services, within 3 working days after completion of my last assignment or it will be considered a voluntary quit. If I fail to do so, the temporary service may interpret that I am not available for work and ineligible for unemployment benefits.

I have read and fully understand the above statements regarding policies and procedures and agree to the same. I understand that failure to comply with these policies and procedures could lead to my termination and may jeopardize my insurance benefits. I was presented the opportunity to ask questions and willingly agree to all of the above. I understand a copy of this form is available to me.

Received by: _____
Employee Signature

Employee: _____ Date: _____
Print Employee Name

Presented by: _____
Sedona Staffing Representative

Print name: _____ Date: _____
Print Sedona Representative Name

SEDONA STAFFING SERVICES
NOTIFICATION OF BACKGROUND INVESTIGATION

It is the intent of Sedona Staffing Services, to attract and retain quality employees in an attempt to maintain a productive, safe and profitable workplace. In order to accomplish this, Sedona Staffing Services engages in the practice of conducting background investigations on all qualified individuals being considered for employment with Sedona Staffing Services, for assignment to our client. This investigation may concern itself with information pertaining to an applicant's general reputation, personal character, work history and such other information, which aids in our evaluation in determining suitability for employment. The investigation may include, but is not necessarily limited to a criminal record check, driver's license check, civil record check, education and employment verification, and any other inquiry deemed necessary to make a proper evaluation.

I hereby acknowledge that information gathered during the background process may be used to determine my suitability for employment. I hereby authorize this Company and/or it's agents to conduct said background investigation and to make all inquiries necessary to assist in making a decision regarding my employment. I understand that any information gathered by this company for this purpose will be held confidential and disseminated on a need to know basis only. I understand that the information may be shared with a Client to which I am being considered for placement.

I hereby authorize any and all law enforcement agencies, employers, credit agencies, educational institutions, or any other individual or organization to release a copy of my records to Sedona Staffing Services, or it's agents, and hereby release the same from all liability for such disclosure. A photocopy or facsimile of this authorization and release shall be considered as effective and valid as the original.

I understand that if I am denied employment based on information obtained during the background investigation that the information obtained is available upon written request. I have the right to challenge any information deemed by me to be incorrect and will be offered the opportunity to provide adequate documentation to show why it is incorrect.

Signature

Witness

Date

Date

Violence in the Workplace

Sedona Staffing Services strives to maintain a pleasant and safe work environment free from harassment, intimidation, threats, physical abuse, or other hostile or inappropriate behavior. Further, we prohibit the use or possession of weapons on company property at any time. Examples include, but are not limited to:

- Striking or shoving an individual
- Threatening harm to an individual or his/her family, friends, associates, or property
- Intentionally damaging, destroying, or threatening to damage or destroy the company's or an individual's property
- Stalking an individual or his/her family, friends, associates
- Harassing or threatening phone calls or other forms of communication

Anyone engaging in any of the above behavior will face discipline up to and including termination of employment.

An employee who has been the subject of violent or threatening behavior, or who knows of a potentially violent situation, should immediately report the matter to his/her supervisor, Human Resources, or any other member of management. If an employee feels there is an immediate serious threat to himself/herself or to others, law enforcement authorities may be contacted directly. Supervisors are required to report to Human Resources any acts of violence or threatening behavior.

Reports of these acts will be promptly and thoroughly investigated. Confidentiality will be maintained to the extent possible. If the investigation reveals that an employee behaved in a violent or threatening manner, that employee will be subject to disciplinary action, up to and including termination of employment.

Sedona Staffing reserves the right to conduct searches and inspections of employees' personal property or company provided materials such as lunch containers, purses, desks, personal computer files, cabinets, file drawers, or packages on company premises. Any illegal or unauthorized articles discovered may be taken into Sedona Staffing's possession and may be turned over to law enforcement representatives. Employees will first be asked to voluntarily cooperate with company requested searches. Any employee who refuses to submit to a search or is found in possession of prohibited articles may be subject to discipline up to and including termination of employment.

Associate's Signature

Date

Print Name


SEDONA
STAFFING SERVICES



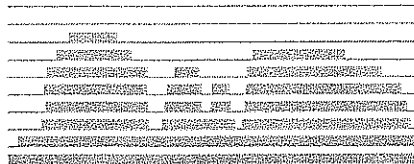
Essential StaffCARE

Health Insurance Enrollment Form

Complete the Enrollment Form to Elect or Decline Coverage

- You **MUST** Complete the Enrollment Form for the New Hire Process
- You **MUST** Elect or Decline Medical Coverage on the Enrollment Form
- You **MUST** Sign the Bottom of the Form, even if you Decline Coverage
- Return the Enrollment Form to your Branch Manager
- Keep the Plan Information Packet for Your Records

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.



SEDONA STAFFING




SST

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

The Essential StaffCARE Medical/Rx, Accidental Death and Dismemberment, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 24.220, 26.212 and 26.213. The Term Life and Short-Term Disability Plans are underwritten by BCS Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

Form: ESC S 10D v10.2



STEP 1: You **MUST** complete the Employee Information Section as part of your new hire process.



Essential StaffCARE

Plan Information Packet

Please keep for your records.




STEP 2: You **MUST** Accept or Decline coverage.

Member Services:

Essential StaffCARE Customer Service: 1-866-798-0803

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, policy booklets, and to add, change, or cancel coverage.
- Customer Service Call Center hours are M - F 8:30 a.m. to 8 p.m. Eastern Time. Bilingual representatives are available.
- Members can also visit www.essentialcare.com/members and click on Essential StaffCARE.



STEP 3: You **MUST** Sign and Date here.
Even if you decline coverage.

EMPLOYEE INFORMATION
(Must Be Filled Out)

ENROLLMENT FORM - 10k PLAN

USE BLACK or BLUE INK ONLY

Social Security Number --

Date of Birth / / Sex M F

Name _____

Street Address _____

City _____ State Zip

Home Phone --

Do you or any dependents have Medicare?

Yes No If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date / /

Names of Covered Person(s)

1. _____
2. _____
3. _____
4. _____

- You MUST enroll in the Medical Insurance Plan before adding any additional benefits.
- Your coverage level for the additional benefits will be identical to your medical plan selection.

BENEFIT SELECTION

Weekly Rates

MEDICAL

- \$23.69 Employee Only
- \$48.08 Employee +1
- \$64.20 Employee + Family
- NO to all benefits.
If checked, stop! Go no further.

DENTAL

- YES \$5.23 Employee Only
- YES \$10.46 Employee +1
- NO \$17.26 Employee + Family

VISION

- YES \$2.35 Employee Only
- YES \$4.00 Employee +1
- NO \$5.64 Employee + Family

TERM LIFE

- YES \$0.60 Employee Only
- YES \$0.90 Employee +1
- NO \$1.80 Employee + Family

SHORT-TERM DISABILITY

- YES \$4.20 Employee Only
- NO

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number --

Date of Birth / / Sex M F

Relationship: Spouse Domestic Partner Child

Name _____

Social Security Number --

Date of Birth / / Sex M F

Relationship: Spouse Domestic Partner Child

Name _____

Social Security Number --

Date of Birth / / Sex M F

Relationship: Spouse Domestic Partner Child

Name _____

Social Security Number --

Date of Birth / / Sex M F

Relationship: Spouse Domestic Partner Child

BENEFICIARY INFORMATION

For Term Life and Accidental Death & Dismemberment please write in your Beneficiary information.

NAME OF BENEFICIARY _____

RELATIONSHIP _____

Accidental Death & Dismemberment is part of the Medical Benefit.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no medical selection is a declination of coverage.

► Signature _____

Date / /

Essential StaffCARE PROGRAM OVERVIEW & FREQUENTLY ASKED QUESTIONS

How do I enroll?

Enrolling in the Essential StaffCARE plan is easy. You can enroll by completing an Essential StaffCARE enrollment application and returning it to your manager.

When can I enroll in the plan?

As a full-time and/or part-time employee, you are able to enroll in the Essential StaffCARE program within 30 days of your hire date, 1st paycheck date, or your employer's annual 30 day open enrollment period. If you do not enroll during one of these time periods, you will have to wait until the next annual open enrollment, unless you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

What is a qualifying life event?

A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Loss of insurance coverage by your spouse
- Death of an immediate family member
- Medicare entitlement
- Employer bankruptcy
- Loss of dependent status
- Loss of prior coverage

In addition, you may request a special enrollment (for yourself, your spouse, and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit.

Are dependents covered?

Yes. Your eligible dependents are your spouse and your children up to age 26.

When does coverage begin?

Coverage will begin the Monday following a payroll deduction and continues as long as you have a deduction from your paycheck. Please review your check stub for deductions. If you miss a payroll deduction, to avoid a break in coverage, you may make direct payments to PAI. After six consecutive weeks without a payroll deduction or direct premium payment, coverage will be terminated and COBRA information will be sent at that time.

If I complete an enrollment form, but do not get placed on assignment right away, will I have to complete a new form?

After six months if there has not been a deduction from your paycheck, please fill out a new enrollment form. Missing information will delay the process.

Can I make changes or cancel coverage?

You may cancel or reduce coverage at any time unless your premiums are deducted pre-tax. You will only have 30 days from your hire date or first paycheck date to enroll, add additional benefits or add additional insured members. After this time frame, you will only be allowed to enroll, add benefits or add additional insured members during your annual open enrollment period or within 30 days of a qualifying life event.

How can I make changes?

To make changes or cancel coverage by telephone call (800) 269-7783. Enter your PIN CODE plus the last four digits of your Social Security number (SSN).

PIN CODE: 142 + _ _ _ _
(last four digits of your SSN)

Remember, it may take up to two or three weeks for the changes or cancellation to be reflected on your paycheck. Coverage will continue as long as you have a paycheck deduction.

Essential StaffCARE PROGRAM OVERVIEW & FREQUENTLY ASKED QUESTIONS

Do I have to go to an In-network provider?

It is not required that you go to an in-network provider. However, if you choose a provider who participates in the PPO network, you receive two key advantages:

- PPO discount for all services.
- The provider will file the claim to the plan.

When should I expect an ID card?

ID cards will be mailed as soon as your enrollment form is received and processed. You should receive your ID card within 7-10 days of your effective date.

Are maternity benefits covered?

Yes, maternity benefits are covered the same as any other condition under this plan.

Is there coverage for contraceptives on this plan?

Yes, oral contraception is covered under the prescription benefits. However, non-oral contraceptives are not covered.

NETWORK INFORMATION

Prescription Drug Network

If enrolled in the medical plan, you are automatically covered by the prescription drug program through the Caremark Pharmacy Network. Caremark has a national network with over 58,000 participating pharmacies. To find a local participating Caremark pharmacy, you can visit www.caremark.com. Prescription drug benefit information can be found on the Benefits at a Glance page.

Stretch Your Benefit Dollars

This benefit plan offers you and your family savings for medical care through discounts negotiated with providers and facilities in the Beech Street Network, PHCS Network, or Multiplan Network. Choosing an in-network provider helps maximize benefits. When you use an in-network provider, you will automatically receive the network discount and the doctor's office will file the claim for you. If you use a doctor who is not part of the network, you will not receive the discount and you may need to file the claim yourself.

How Do I Locate a Doctor?

Enrolled members are encouraged to visit providers in the networks listed in order to maximize their benefit dollars. To find a participating provider or verify your current medical provider is in-network, please call or visit the network websites referenced on this page.

Member ID Cards

An ID card and confirmation of coverage letter will be mailed to your home address. If you do not receive these documents within 10 business days of your effective date, or have a change of address, please contact the Essential StaffCARE Customer Service at **866-798-0803**. Present your ID card to the provider at the time of service. These ID cards are used for identification purposes and providers use them to verify eligibility status.

Medical

- Beech Street
1-866-907-3619
www.beechstreet.com
(available except where other networks are used)
- PHCS Network
1-866-671-7427
www.phcs.com
(available for residents of Arkansas and Utah)
- Multiplan Network
1-888-342-7427
www.multiplan.com
(available for residents of West Virginia)

Prescription

- Caremark
1-888-963-7290
www.caremark.com

Vision

- EyeMed Vision Care
1-866-723-0513
www.eyemedvisioncare.com

Dental

- DenteMax
1-800-752-1547
www.dentemax.com

Do not contact the above Networks for questions regarding your medical benefits. All medical benefit questions should be directed to the Essential StaffCARE Member Services line at 866-798-0803.

BENEFITS AT A GLANCE

Policy Number

225100-SST

Medical Benefits - Plan 10k

Weekly Rates

Annual Plan Maximum (per person, all expenses)	\$10,000	Outpatient Benefits ²	
Annual Deductible - Individual	\$200	Annual Outpatient Maximum (per person)	\$1,500
Annual Deductible - Family	\$500	Outpatient Co-insurance ¹	80%
Inpatient Benefits ¹		Physician Office Visit Co-pay ³	\$15
Plan Co-insurance	80%	Physician Office Visit Co-insurance ³	100%
Daily Room & Board	\$400	Prescription Drug Benefit ³	
Daily ICU Room & Board	\$800	Monthly Maximum (no carryover)	\$50
Other Hospital Services Maximum	\$1,500	Generic / Branded Co-pay (per script)	\$10 / \$30
Wellness Benefit ³			
Annual Wellness Benefit Maximum	\$100	Wellness Benefit Co-pay	\$15
Accidental Death and Dismemberment			
Employee Amount	\$10,000 ⁴	Child Amount (6 months to 24 years old)	\$5,000
Spouse Amount	\$5,000	Infant Amount (15 days to 6 months)	\$1,000
Employee Only \$23.69		Employee + One \$48.08	Employee + Family \$64.20

¹ All outpatient benefits are subject to the outpatient maximum ² subject to annual outpatient maximum ³ annual deductible does not apply

⁴ Reduces to \$7,500 at 65, \$5,000 at 70

Dental Benefits

Weekly Rates

	Waiting Period	Co-insurance	Annual Maximum Benefit	Deductible
Coverage A	None	80%	\$750	\$50
Coverage B	3 months	60%	Exams, Cleanings, Intraoral Films and Bitewings	
Coverage C	12 months	50%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures	
			Periodontics, Crowns, Bridges, Endodontics and Dentures	
Employee Only \$5.23		Employee + One \$10.46	Employee + Family \$17.26	

Vision Benefits

Weekly Rates

	Frequency	Coinsurance	Deductible	Maximum Benefit
Eye Examination for Glasses	1 visit per 12 months	80%	\$5 per visit	\$25
Choice A: Eye Glasses				
Lenses	2 lenses per 12 months	75%	\$15 per purchase	\$35-\$75
Frames	1 pair per 12 months	75%	\$15 per purchase	\$25
Choice B: Contact Lenses	2 lenses per 12 months	75%	\$15 per purchase	\$95
Choice C: Disposable Lenses	Up to a 12 month supply per 12 months	75%	\$15 per purchase	\$75
Employee Only \$2.35		Employee + One \$4.00	Employee + Family \$5.64	

Short-Term Disability

Weekly Rates

Benefit	60% of Salary up to \$150 per week	Waiting Period / Maximum Benefit Period	7 days / 26 weeks
Employee Only \$4.20			

Term Life Benefits

Weekly Rates

Employee Amount	\$10,000 (Reduces to \$7,500 at 65, \$5,000 at age 70)	Child Amount (6 months to 24 years old)	\$5,000
Spouse Amount	\$5,000 (Terminates at age 70)	Infant Amount (15 days to 6 months)	\$1,000
Employee Only \$0.60		Employee + One \$0.90	Employee + Family \$1.80

EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

MEDICAL AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane;
- Declared or undeclared war;
- Serving on full-time active duty in the armed forces;
- The covered person's commission of a felony;
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law; or
- Applicable only to Accidental Death and Dismemberment: Bodily or mental infirmity; disease of any kind; or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound or accidental ingestion of a poisonous food substance.

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions;
- Hearing examinations or hearing aids;
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident;
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force;
- Services provided by a member of the covered person's immediate family.

PRESCRIPTION DRUGS: No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

DENTAL: The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

PRE-EXISTING CONDITIONS: No benefits will be paid for a pre-existing condition (one you had treatment for within the six month period ending the day before your enrollment date) for the first 12 months of your coverage (may vary by state). This does not apply to pregnancy nor to dependent children up to age 19. The exclusion period may be reduced by most previous medical expense coverage ("creditable coverage"), if there is no more than a 62-day break in coverage. You should give us a copy of any certificates of creditable coverage. If you do not have a certificate, but have prior health coverage, we will help you obtain one from your prior plan. There are also other ways to demonstrate you have creditable coverage, so contact us if you need help. All questions about the pre-existing condition exclusion and creditable coverage should be directed to: Essential StaffCARE Unit Supervisor, Planned Administrators, Incorporated (PAI), P.O. Box 6702, Columbia, SC 29260, or call us at: (866) 798-0803.

VISION: No benefits will be paid for any materials, procedures or services provided under worker's compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury;
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent; or a person who resides in your home;
- Declared or undeclared war or act of war;
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony;
- Your participation in a riot;
- If you engage in an illegal occupation;
- Release of nuclear energy;
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

Short-Term Disability benefits are not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

TERM LIFE: No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.