Acrobat outsourcing
Your Hospitality Staffing Professionals

Employment Application
(NEW JERSEY)

Acrobat Outsourcing is an equal opportunity employer dedicated to non-discrimination in all employment practices. Acrobat Outsourcing selects the best qualified individual for the job based on job-related qualifications regardless of race, age (40+), color, religion, gender, national origin, ancestry, marital status, sexual orientation, disability or any other status protected by applicable law.

PLEASE PRINT

Full Name Akilah Frank Date: 08/23/2016

Cell ~~Home~~ Telephone (973) 932 8275 Other Telephone (862) 438 4971

Present Address 251 Stuyvesant Ave. Apt 1, Newark NJ, 07106

Permanent Address, if different from present address: Same as above

Email Address ~~KilahKeelFrank~~ kilahkeel1089@gmail.com

EMPLOYMENT DESIRED

Position applying for: _____ Salary desired: $9.00

Are you currently registered with any staffing and/or employment agencies? If so, please list

_____

Are you applying for: Full-time work? Yes___ No___ Part-time work? Yes ✓ No___

Temporary work, e.g., summer or holiday work? Yes ✓ No___ From: _____ To: _____

How did you find out about our open position? (Please check fill in proper name of source):

Referral ☑ Name of Referral Mary (Sudexo) Newspaper ☐ Job Fair ☐ Agency ☐ Company Website ☐

Other Web Posting ☐ Other Source ☐

Could you work overtime, if necessary? Yes ✓ No___ If hired, on what date could you start working? ASAP

Please keep in mind that schedules and shifts may vary depending on position and season. Additionally, the hours may vary from week to week, depending on the company needs. Please list only the times/days you're available to work below.

SPECIFY HOURS AVAILABLE DAILY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
AM	Open	N/A	8:00a	N/A	8:00a	~~None~~	Open
PM	Close	N/A	2:00p	N/A	2:00p		Close

Do you have any vacations or extended leaves planned in the next 12 months? If so, please list dates:

PERSONAL INFORMATION

Have you ever applied to or worked for Acrobat Outsourcing before? Yes___ No ✓ If yes, when? _____

Do you have friends or relatives working for Acrobat Outsourcing? Yes___ No ✓ If yes, please state name and relationship

_____

If hired, would you have a reliable means of transportation to and from work? Yes ✓ No___

If hired, can you present evidence of your legal right to live and work in this country? Yes ✓ No___

State age if you are under 18 _____. If you are under 18, hire is subject to verification that you are of minimum legal age to work.

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Are you able to perform the essential functions of the job for which you are applying? Yes ✓ No ___

If no, describe the functions that cannot be performed. (Note: We comply with the ADA and consider reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions.) ___

Pursuant to the Opportunity to Compete Act, we will consider for employment qualified applicants with arrest and conviction records.

EDUCATION & SKILLS

NAME OF SCHOOL	CITY & STATE	GRADE OR DEGREE COMPLETED	DID YOU GRADUATE?
NJCU	Jersey City, NJ	BFA	last year
Essex County College	Newark, NJ	AA	Yes
Do you have any special licenses, certificates or special training? If so please list under "Special".		YES	(NO)
Are you computer literate? If so, list software knowledge under "Special."		(YES)	NO
Are you proficient with Point of Sales Systems? If, so please list which ones under "Special."		YES	(NO)
Do you have any other experience, training, qualifications or special skills, which you feel make you especially suited for work at Acrobat Outsourcing? If so, please list under "Special."		YES	NO
Special:			

EMPLOYMENT HISTORY

List below all present and past employment starting with your most recent employer (last 10 years is sufficient). Account for unemployment periods of three months or more.

Are you currently employed? Yes ✓ No ___ ***If so, may we contact your current employer?*** Yes ✓ No ___

Name and Address of Employer NJCU Visual Arts gallery 100 culver A Jersey City N

Type of Business Art Gallery Telephone No. (201) 779 0911 Supervisor's Name Midori Yoshim

Your Position and Duties assting Gallery director with installatior and break down, greeting visitors, and assisting oth Assist

Dates of Employment: From Jan/2014 To ___ Weekly Pay: Starting $8.00 Ending $9.00

Reason for Leaving: ___

Name and Address of Employer ~~100 Culver Ave Jersey City NJ~~ 50 New St. Irvington NJ 07111

Type of Business DayCare Telephone No. (___) ___ Supervisor's Name Kelly Mitchel

Your Position and Duties Teacher's Assistant, ~~Aide~~ Assisting teachers with day to day activities.

Dates of Employment: From 2/03 To 5/12 Weekly Pay: Starting 7.25 Ending 7.25

Reason for Leaving: Laid off.

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Name and Address of Employer _____

Type of Business _____ Telephone No. (____) _____ Supervisor's Name _____

Your Position and Duties _____

Dates of Employment: From _____ To _____ Weekly Pay: Starting _____ Ending _____

Reason for Leaving: _____

Name and Address of Employer _____

Type of Business _____ Telephone No. (____) _____ Supervisor's Name _____

Your Position and Duties _____

Dates of Employment: From _____ To _____ Weekly Pay: Starting _____ Ending _____

Reason for Leaving: _____

Have you ever been fired from any previous place of employment? If so, please explain: _____

MILITARY SERVICE

Have you obtained any special skills or abilities as the result of service in the military? Yes___ No ✓
If so, describe: _____

JOB RELATED REFERENCES

List below three persons not related to you who have knowledge of your work performance within the last three years.

Name: Midori Yoshimoto Telephone No. (____) _____

Address _____

Occupation: Gallery Director/Professor Relationship: Supervisor Number of Years Acquainted: 3

Name: Valeri Fisher Telephone No. (862) 205 7013

Address _____

Occupation: Airpot Security Relationship: personal Number of Years Acquainted: 10

Name: Shaneek Daley Telephone No. (973) 842 5583

Address _____

Occupation: personal nurse Relationship: personal/business Number of Years Acquainted: 11

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Please Read Carefully, Initial Each Paragraph and Sign Below

A.F. I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material facts on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

A.F. I hereby authorize Acrobat Outsourcing to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to the company any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release the company, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

A.F I hereby authorize Acrobat Outsourcing and its authorized representatives to solicit information regarding my background, which may include but not be limited to, information about my employment, education, and/or criminal history, which may be in the files of any federal, state, or local criminal justice and law enforcement agency and general public records history.

A.F. I understand that if selected for hire, it will be necessary for me to provide satisfactory evidence of my identity and legal authority to work in the United States, and that federal immigration laws require me to complete an I-9 form in this regard within three days of my hire date.

A.F. Acrobat Outsourcing is an at-will employer. I understand that nothing contained in the application, or conveyed during any interview, which may be granted or during my employment, if hired, is intended to create an employment contract between me and the company. In addition, I understand and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice, with or without cause, at the option of either myself or the company, and that no promises or representations contrary to the foregoing are binding on the company unless made in writing and signed by me and the company's designated representative.

I hereby acknowledge that I have read and understand the above statements.

Applicant's Signature _____ **Date** 08/23/2016

E-Verify

Welcome
Debbie McKee

MENU

Verify Employee

Employee Name
Frank, Akilah

Case Verification Number
2016244101700CU

View/Print Case Details

Case Closed

Employment Authorized

You have closed case 2016244101700CU. Record this case verification number on the employee's Form I-9 or print the case details and keep on file.

Last Name
Frank

First Name
Akilah

Middle Initial
--

Other Names Used
--

Date of Birth
October 05, 1989

Social Security Number
*** ** 9548

Employee's Email Address
--

Citizenship Status
A lawful permanent resident

Alien Number
057303392

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al* ***(800) 736-7401*** *para oír información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* Akilah Frank Today's Date. *Fecha de Hoy.* 08/11/17
2. Home Address. *Dirección Residencial.* 251 Stuyvesant Ave. Apt 1
3. City. *Ciudad.* Newark State. *Estado.* NJ Zip. *Código Postal.* 07106
4. Date of injury. *Fecha de la lesión (accidente).* 07106 Time of Injury. *Hora en que ocurrió.* ___ a.m. 1:00 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurió el accidente.* Fresh City
   St Barnabas Medical Center - 94 Old Short Hills rd.
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* 4 Cuts to the Skin and nail of the Right thumb
7. Social Security Number. *Número de Seguro Social del Empleado.* 9548
8. Signature of employee. *Firma del empleado.* AK

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* Fresh City Living Ston
10. Address. *Dirección.* 94 Old Short Hills Rd Living Ston NJ 07039
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 8-11-17
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 8-11-17
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 8-11-17
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.*
    Gallagher Bassett
15. Insurance Policy Number. *El número de la póliza de Seguro.* LDC4042609 AOS
16. Signature of employer representative. *Firma del representante del empleador.*
17. Title. *Título.* Manager 18. Telephone. *Teléfono.* 973 822-2509

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

Acrobat outsourcing
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665 Third Street, Suite 415
San Francisco, CA 94107
(415)-431-8826
www.acrobatoutsourcing.com

Form 1 (Rev. 10/11)
(Approved for use as OSHA 101 and 301)

EMPLOYER FIRST REPORT OF INJURY

Complete form and send original to the Human Resources within 24 hours of the event. Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee Social Security Number MUST be provided.

EMPLOYER

1. Legal Name: **Acrobat Outsourcing**
2. Business Name: **S.E. Scher Corp dba Acrobat Outsourcing**
3. Mail Address: No. and Street: **665 3rd Street Suite 415** City: **San Francisco** State: **CA** Zip: **94107**
4. Location (if different from Mail Address): Fresh City Livingston
5. Federal ID No.: **95-4643269**
6. Nature of Business (list principal products or service of concern): **Staffing Company**
7. Do you regularly employ 10 or more employees? XXX Yes ☐ No
8. Telephone No.: **415-431-8826**

EMPLOYEE

9. Name: First Name: Akeiah | Middle Initial: | Last Name: Frank
10. Social Security No.: 135-17-9548
11. Date of Birth: 10-5-1989
12. Home Address: No. and Street: 251 Stuyvesant Ave. Apt 1
13. Telephone No.: 973-932-8275
14. Job Title: FSW
15. Age: 27
City: Newark | State: NJ | Zip: 07106
16. Dept. assigned to:
17. Sex: ☐ M ☒ F
18. Wages $ 9-10 Per Hour
Hours Per Day: Varies Days Per Week
19. If board, lodging, etc. were furnished in addition to wages, state estimated value $
20. Was employee hired in CA? ☐ Yes ☒ No
21. Date of Hire: 8-31-2016

ACCIDENT OR EXPOSURE TO OCCUPATIONAL DISEASE

22. Date of Accident: 8-10-17
Accident Time: AM 1 PM
Began Shift: 7:45 AM PM
23. Location of Accident: Town or City: Livingston State: NJ
24. Machine or tool involved in the accident: Dices
25. Was it defective? ☐ Yes ☒ No
26. On employer's premises? ☒ Yes ☐ No
If yes, name of department: Fresh City
27. Object or substance directly causing injury: Dicer
28. Describe what employee was doing: Dicing Tomato
Was this the employee's regular occupation? ☒ Yes ☐ No
29. Employee Description of Incident. Details:
Cut finger on Tomato dicer.
Right Thumb.

NATURE OF INJURY

30. Describe the injury and the part of the body injured: Cut to Right Thumb
31. **Was this a first-aid only injury:** ☒ Yes ☐ No
32. Any Lost Time? ☐ Yes ☒ No
If yes, date disability began:
Last date paid in full:
33. Employee returned to work? ☒ Yes ☐ No
If yes, date: 8-11-17
At what weekly wage: varies
34. Did injury result in death? ☐ Yes ☒ No
If yes, date of death:
35. If death, name and address of nearest relative
Relationship:
36. Name and address of Physician
37. Name and address of Hospital
38. Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name
Remained Overnight ☐ Yes ☒ No

Name in full: ~~Gallagher Bassett~~
Policy No: LDC4042609 AOS
Signed by: [signature]
Employer or Representative
Title: Manager
Date: 8-11-17

___Provided Form 8 ___Dept. of Labor ___Ins. Co. ___Employer ___Employee

Equal Opportunity is the Law

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SUPERVISOR STATEMENT

Please print. Submit to Human Resources via E-mail hr@acrobatoutoutsourcing.com or via Fax (415) 431-1580

I, Aishah Edrey, was the Supervisor on thursday, August 10, 2017 when Akilah Finger was cut with the tomato dicer.

False Statement Disclosure:

By signing this document you attest that the information provided by you the (Employee/Supervisor) is to the best of your knowledge truthful and correct. Providing false information or omitting pertinent information regarding this statement will lead to termination.

Employee Signature

Date:

Supervisor Signature:

Date: 8/11/17

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EMPLOYEE INCIDENT REPORT

This form is to be completed by the employee. Please print. Submit to HR via E-mail hr@acrobatoutsourcing.com or via Fax (415) 431-1580.

Accident Information & Location

Date of Accident: 08/10/17
Time of Accident: 1:00 pm
Date Supervisor Notified: Fred
Time Notified: 1:50
Location Name: Fresh City Kitchen
Department Name:

Employee Information

Full Name: Akilah Frank
Address: 251 Stuyvesant Ave, Apt 1 Newark, NJ 07106
Social Security Number: 9548
EE ID:
Description of Injury: Cut on the Right thumb by the tomato dicer

Medical Treatment Beyond First Aid: ☐Yes ☑No ☐Unknown
Has the employee been tested for drugs or alcohol: ☐Yes ☐No ☐Unknown
Did the employee miss work beyond their normal shift: ☐Yes ☑No ☐Unknown
How many days missed: N/A Safeguards/ Safety Equipment used: ☐Yes ☑No ☐Unknown
Body part Injured: Right thumb Type of Injury: Cut
Number of days missed from work: N/A
Was employee taken by emergency transportation? ☐Yes ☑No ☐Unknown
Admitted to hospital? ☐Yes ☑No ☐Unknown
If yes, Still in hospital? ☐Yes ☑No ☐Unknown

Recommendation on how to prevent this accident form recurring:

Medical Care information:

Hospital Information Available *(If yes, the following will display)* ☐Yes ☐No ☐Unknown
Name of Hospital and address:
Urgent Care address:
Comments:

False Statement Disclosure:

By signing this document, you attest that the information provided by you (the Employee) is to the best of your knowledge truthful and correct. Providing false information or omitting pertinent information regarding the claim will lead to termination. Any employee discovered to be making a fraudulent claim will be reported to the Department of Insurance Regulation and persecuted to the full extent of the law.

Employee Signature: Akilah Frank
Date: 08/11/17

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Corporate Headquarters
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Phone: 415-431-8826 | Fax: 415-431-1580
www.acrobatoutsourcing.com

REFUSAL OF MEDICAL TREATMENT OR OBSERVATION FORM

Employee's Name (Print): Akilah Frank

Work Location: Supervisor: _____

Witness(es): Stephan Buckham

Nature of Injury/Condition: 4 cut and black and blue

Description of Injury [Body Part(s) Injured]: right thomb

Brief Narrative Description of the Incident:
I was dicing tomatos, when I accidentally drop the dicer onto my right thomb causing 4 cuts (2 on the nail and 2 on the skin).

I, Akilah hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of Acrobat Outsourcing for the work related injury I incurred on (date) 08/10/17. By signing this form, I realize that it does not necessarily affect my later eligibility for Workers' Compensation. I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. At a later time, I understand that I may request from my supervisor(s) a medical authorization to obtain medical treatment and/or observation for the above described injury; which request can then be either approved or denied.

AK 08/11/17

Employee's Signature Date