

**NOTICE TO EMPLOYEE**

Labor Code section 2810.5

**EMPLOYEE**

Employee Name:

Ocest Shanynguk

Start Date:

0/13/17**EMPLOYER**Legal Name of Hiring Employer: S.E ScherIs hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])?  Yes  No

Other Names Hiring Employer is "doing business as" (if applicable):

Acrobat Outsourcing

Physical Address of Hiring Employer's Main Office:

665 Third St. Suite 415, San Francisco, CA. 94107

Hiring Employer's Mailing Address (if different than above):

Hiring Employer's Telephone Number: 415-431-8826

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: \_\_\_\_\_

Physical Address of Main Office: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**WAGE INFORMATION**Rate(s) of Pay: \$14/Dish & Cash Overtime Rate(s) of Pay: 1.5XRate by (check box):  Hour  Shift  Day  Week  Salary  Piece rate  Commission Other (provide specifics): \_\_\_\_\_Does a written agreement exist providing the rate(s) of pay? (check box)  Yes  NoIf yes, are all rate(s) of pay and bases thereof contained in that written agreement?  Yes  No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances): \_\_\_\_\_

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: FRIDAY

## WORKERS' COMPENSATION

Insurance Carrier's Name: Integro USA Inc. dba Integro Insurance Brokers

Address: 1 State Street Plaza, 9th floor, New York, NY. 10004

Telephone Number: 212-295-5440

Policy No.: LDC4042609 AOS

Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: \_\_\_\_\_

### PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

- a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
- b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
- c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
  1. requesting or using accrued sick days;
  2. attempting to exercise the right to use accrued paid sick days;
  3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
  4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: (Check one box)

- 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
- 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
- 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.
- 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption): \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT

(Optional)

Jamie Goodwin  
(PRINT NAME of Employer representative)

6/13/17  
(SIGNATURE of Employer Representative)  
(Date)

Orest Shaynyuk  
(PRINT NAME of Employee)

6/13/17  
(SIGNATURE of Employee)  
(Date)

The employee's signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.



Acrobat Outsourcing  
Corporate Headquarters  
665 Third Street, Suite 415, San Francisco, CA 94107  
Phone: 415-431-8826 | Fax: 415-431-1580  
www.acrobatoutsourcing.com

### GLOBAL CASH CARD FORM

New  Replacement  Cancel

Today's Date

06 - 13 - 2017

Last Name

SHAYNYUK

First Name

Orest

MI

W

Address

111 TAYLOR STREET 133

Apartment #

City

SAN FRANCISCO CA 94102

State

Zip Code

Social Security Number

608-56-3142

Date of Birth

02-13-1992

INFORMATION TO BE COMPLETED BY ACRÓBAT REPRESENTATIVE ISSUING CARD  
INCLUDE A PHOTOCOPY OF THE CARD WITH THIS FORM:

ACCOUNT NUMBER (16-digits)

4853 - 4001 - 8175 - 4427

Branch Office:

Completed By:

Global Cash Card | 7 Corporate Park, Suite 130 | Irvine, CA 92606 | CSR: 1-888-220-4477

Payroll Statements can be viewed online at: [www.globalcashcard.com](http://www.globalcashcard.com)

I hereby release Acrobat Outsourcing the following information to establish my Global Cash Card account and enroll into an automatic payroll deposit. I authorize Acrobat Outsourcing to debit/credit my account. I have verified my information above and understand that any cash card charges incurred are my responsibility. I agree to the terms and conditions under which Global Cash Card Prepaid ATM Card is issued.

Please agree to the following:



By selecting this check box, you have agreed to the following statement: I authorize my employer, or its service or payroll provider, and the specified bank to deposit my net pay or portion thereof, as indicated, into my account each pay date. If funds to which I am not entitled are deposited into my account, I authorize my employer, or its service or payroll provider, to direct the bank to return said funds to my employer, or its service or payroll provider. I understand that my deposit may not be credited to my account until 5:00 PM on the pay date indicated on the check voucher. I understand that it is my responsibility to ensure that my wages are being deposited correctly into my account each pay date.

I also acknowledge it is my responsibility to enter the correct Bank Transit Number and Account Number as to where I want my payroll funds deposited. I understand that if I enter incorrect information that it may delay or prevent my payroll funds being deposited to my accounts. I also acknowledge that any Bank Transit Number that begins with the number 5 is NOT a valid Bank Transit Number and WILL prevent my payroll funds from being deposited into my account. I understand that when Payroll receives the funds back through the banking system it will be paid on the next available pay date.

Print Name

Orest Shaynyuk

Employee Signature

06/13/2017

Date



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### DIRECT DEPOSIT FORM

New

Cancel

Today's Date

  -  -  2  0  -  

Last Name

First Name

MI

Address

Apartment #

City

State

Zip Code

Social Security Number

Date of Birth

Bank Name

\_\_\_\_\_

Checking

Savings

Other

Routing Number

Account Number

Please attach a VOIDED check

This form (and check) may be faxed to the SF Corporate Office at 415-431-1580

Please agree to the following:

By selecting this check box, you have agreed to the following statement: I authorize my employer, or its service or payroll provider, and the specified bank to deposit my net pay or portion thereof, as indicated, into my account each pay date. If funds to which I am not entitled are deposited into my account, I authorize my employer, or its service or payroll provider, to direct the bank to return said funds to my employer, or its service or payroll provider. I understand that my deposit may not be credited to my account until 5:00 PM on the pay date indicated on the check voucher. I understand that it is my responsibility to ensure that my wages are being deposited correctly into my account each pay date.

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Print Name

Employee Signature

Date