Acrobat outsourcing
Your Hospitality Staffing Professionals

Name: Elizabeth Jeffery

Taborca ID: 41321

Date of Hire: ___/___/___

Date of *Re-Act*: 4 / 10 / 2019

New employee set up

- E-verify
- Hire Right EE
- Hire Right Internal (upload any list A docs)
- Direct Deposit (Scan to Payroll) and/or Global Cash Card – complete the form & have EE sign
- Notice to Employee Completed
- Added to Orientation Time Sheet
- Attended New Hire Orientation
- Background Check
- New Hire List (All fields)
- Check Taborca Profile (All fields)
- Upload Resume and Skills Tests (one doc)
- Upload Food Handler's Card

Re Act employee set up (See Re Act Process for more detail)

- File and I9 pulled (new one created/done in Hire Right if old ones are gone)
- Re Act onboarding if initially hired before 1/1/16
- Check W4
- Check all demographic info and availability
- Check for skills tests, app, FHC, and resume (get new app, new resume if hired more than 1 year ago)
- Complete Notice to Employee with updated pay if necessary
- Verify pay option (notify payroll) and take steps to Re Act any old pay options still current
- Run new BGC if more than 1 year since last shift worked
- New orientation/place on time sheet if it's been over a year since last shift
- New Hire List (all fields)
- Delete employee from the INA/TER spreadsheet if they are on it

# Interview Note Sheet

| Applicant Information | |
|---|---|
| Name: Elizabeth Jeffery | Interviewer: McKenna |
| Date: 4/10/19 | Rate of Pay: |
| Position (s) Applied for: Cashier + concessions | Referred by: |

| Test Scores | | | | | |
|---|---|---|---|---|---|
| Server | /35 | % | Bartender | /35 | % |
| Prep Cook | /15 | % | Barista | /15 | % |
| Grill Cook | /40 | % | Cashier | /15 | % |
| Dishwasher | /10 | % | Housekeeping | /16 | % |

| Seeking: |
|---|
| Full-Time |
| Part-Time |

**Relevant Experience & Summary of Strengths**

*Total of _____ in Food Service/Hospitality*

* Reactivate on 4/10

She had a few (3) attendance issues in the beginning of 2018 → she was a caregiver then and had to be home at certain times. Now lives closer and is living with her daughter.

**P.O.S. Experience: Y / N** *details*:_____

**Transportation**

Car Public Transit Carpool ( Rider / Driver )

**Regions Available to work:**

SF City SF North SF Peninsula East Bay Outer East Bay

San Jose South San Jose SJ Peninsula

**Certifications (if any)**

TiPS Serv-Safe LEAD Other _____ Will Submit

**Availability**

Open AM only PM only Weekdays only Weekends only

*Details:*

**Uniforms Owned:**

Bistro Black Bistro Tuxedo 1/2 Tuxedo Black Vest Long Black Tie

Chef Coat Chef Pants Knives Black Pants Non-Slip Shoes Bow Tie Other:_____

| Would you recommend this applicant for Acrobat Academy? | Convention Candidate? | Other Languages Spoken: |
|---|---|---|
| | | |

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Your Hospitality Staffing Professionals

# Attendance Policy

The cost of absenteeism and lateness is difficult to estimate, no one can calculate the cost of the burden this puts on others who have to do the absent person's work. Most people will be late or sick at one time or another. But when short-term absences become more frequent, they might signal personal, medical, or job-related problems.

It is your responsibility to notify your supervisor at least 24 hours prior to your shift of any anticipated tardiness or absence. **All tardiness or absences should be reported to the Emergency Line at 800.236.2276 x2207.** You should provide the general reason for your absence, and understand that excessive absences and lateness will lead to disciplinary action.

Below is a breakdown of how infractions will be measured. Any employee who accumulates more than **three** points in a 90-day period can result in termination of employment.

| | |
|---|---|
| **Tardy** – Anybody not signed/ clocked-in by their start time. | 1 Point |
| **Call Off** – Needing to be taken off a shift after schedules are sent out. It is your responsibility to request any desired time off in advance. | 1 Point |
| **LM Call-Out** – Failing to provide Acrobat with 24-hour notice before missing a shift. | 1 Points |
| **No Call No Show** – Failing to provide Acrobat with any notice before missing a shift. | 3 Points |

Name: Elizabeth Jeffery Date: 4/10/2019

Signature: Elizabeth Jeffery

# NOTICE TO EMPLOYEE

***Labor Code section 2810.5***

## EMPLOYEE

Employee Name: Elizabeth Jeffery

Start Date: 4/10/2019

## EMPLOYER

Legal Name of Hiring Employer: S.E Scher

Is 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: Acrobat Outsourcing

Physical Address of Main Office: 1585 The Alameda, San Jose CA 95126

Mailing Address: " "

Telephone Number: 408 844 0772

## WAGE INFORMATION

Rate(s) of Pay: $17.00 Overtime Rate(s) of Pay: $25.50

Rate 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 □ No

If 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)*

McKenna Brewer
(PRINT NAME of Employer representative)

(SIGNATURE of Employer Representative)

4/10/2019
(Date)

Elizabeth Tetley
(PRINT NAME of Employee)

(SIGNATURE of Employee)

4/10/19
(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.

06/2022

Acrobat outsourcing
Your Hospitality Staffing Professionals

Name: ELIZABETH JEFFERY

Taborca ID: 41321

Date of Hire: 7/28/2017

Date of *Re-Act*: ___/___/___

New employee set up

- ✓ E-verify
- ✓ Hire Right EE
- ✓ Hire Right Internal (upload any list A docs)
- ✓ Direct Deposit (Scan to Payroll) and/or Global Cash Card – complete the form & have EE sign
- ✓ Notice to Employee Completed
- ✓ Added to Orientation Time Sheet
- ✓ Attended New Hire Orientation
- ✓ Background Check (Asurint)
- ✓ New Hire List (All fields)
- ✓ Check Taborca Profile (All fields)
- o Upload Resume and Skills Tests (one doc)
- ✓ Upload Food Handler's Card

Re Act employee set up (See Re Act Process for more detail)

- o File and I9 pulled (new one created/done in Hire Right if old ones are gone)
- o Re Act onboarding if initially hired before 1/1/16
- o Check W4
- o Check all demographic info and availability
- o Check for skills tests, app, FHC, and resume (get new app, new resume if hired more than 1 year ago)
- o Complete Notice to Employee with updated pay if necessary
- o Verify pay option and take steps to Re Act any old pay options still current
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- o New orientation/place on time sheet if it's been over a year since last shift
- o New Hire List (all fields)
- o Delete employee from the INA/TER spreadsheet if they are on it

# Interview Note Sheet

| Applicant Information | |
|---|---|
| Name: ELIZABETH JEFFERY | Interviewer: SONNY |
| Date: 7-28-2017 | Rate of Pay: $13.00 $15.00/HR |
| Position (s) Applied for: PREP - CASH - SERV. 14 | Referred by: JON LEON |

| Test Scores | | | | | |
|---|---|---|---|---|---|
| Server | 30 /35 | 57% | Bartender | /30 | % |
| Prep Cook | 11/20 | 55% | Barista | /10 | % |
| Grill Cook | /40 | % | Cashier | 12/15 | 80% |
| Dishwasher | /10 | % | Housekeeping | /16 | % |

**Seeking:** Full-Time, Part-Time

**Relevant Experience & Summary of Strengths**

*Knife Skills*

Total of _____ in Food Service

* SAN JOSE SCHOOL DIST.
PREP FOOD + SERVING - LARGE VOLUME

* SWEET TOMATOES
FOOD PREP - BREADS/SOUPS

*Cuisines*

1
2
3

* YMCA 300 + GUESTS
COOKED + SERVED
RAN SUMMER CAMP KITCHEN
LEAD COOK

LEFT BUS

*Stations:*

1
2
3

only weekends

P.O.S. Experience: Y / N *details*: _____

**Transportation**

Car | Public Transit | Carpool ( Rider / Driver )

**Regions Available to work:**

SF City | SF North | SF Peninsula | East Bay | Outer East Bay

San Jose | South San Jose | ~~SF Peninsula~~

**Certifications (if any)**

TiPS | Serv-Safe | LEAD | Other _____ | Will Submit

**Availability**

Open | AM only | PM only | Weekdays only | Weekends only

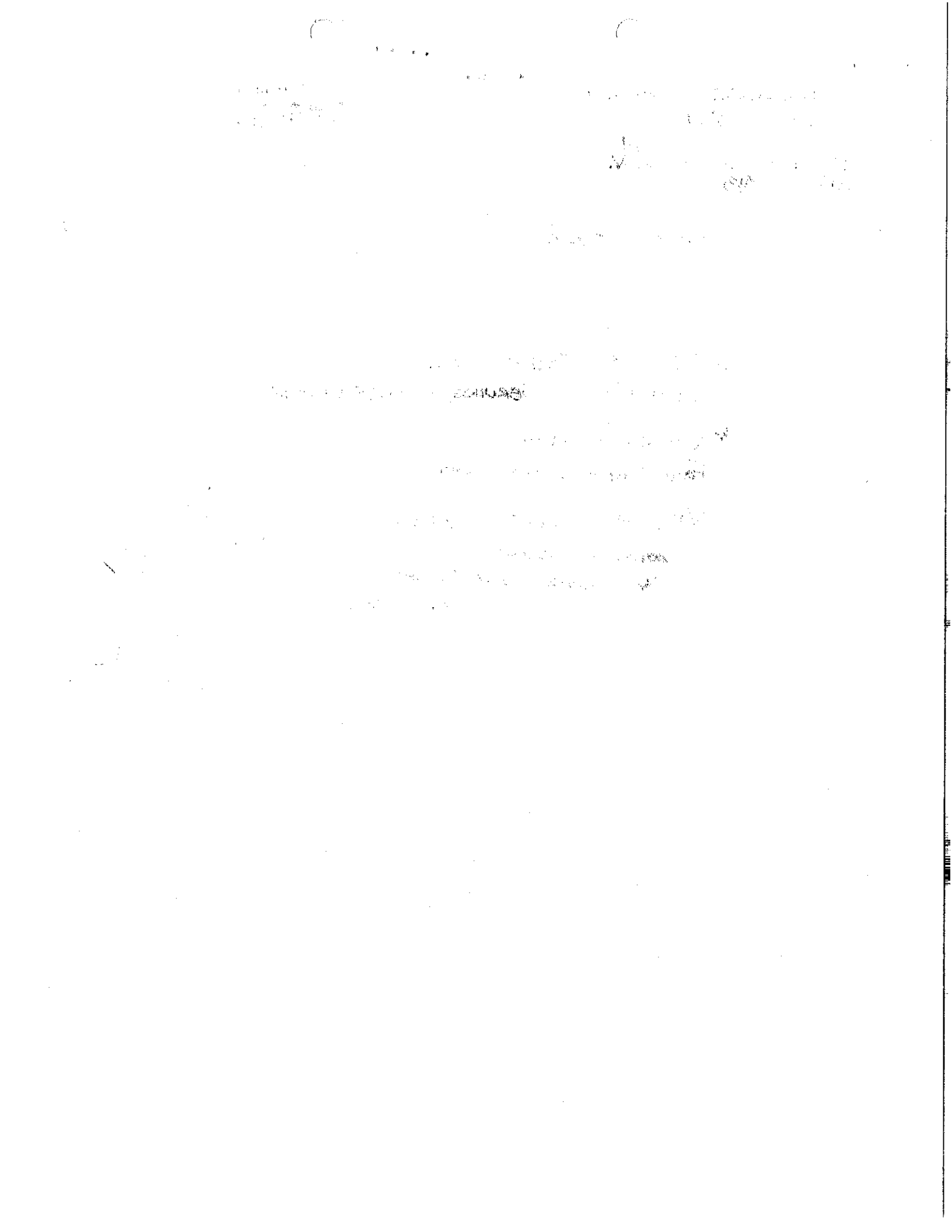
*Details:*

**Uniforms Owned:**

Bistro | Black Bistro | Tuxedo | 1/2 Tuxedo | Black Vest | Long Black Tie

Chef Coat | Chef Pants | Knives | Black Pants | Non-Slip Shoes | Bow Tie | Other: _____

| Would you recommend this applicant for Acrobat Academy? | ~~Convention Candidate?~~ | Other Languages Spoken: |
|---|---|---|
| YES | | SPANISH |



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 Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión 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 "felonia".**

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

1. Name. *Nombre.* Elizabeth Jeffery Today's Date. *Fecha de Hoy.* 8/4/17
2. Home Address. *Dirección Residencial.* 15941 View field Rd.
3. City. *Ciudad.* Monte Sereno State. *Estado.* CA. Zip. *Código Postal.* 95030
4. Date of Injury. *Fecha de la lesión (accidente).* 8/4/17 Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* Sunnyview Retirement 22445 Cupertino Rd. Cupertino CA 95014
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* HURT ARM after falling over a CART
7. Social Security Number. *Número de Seguro Social del Empleado.* 565 27 9525
8. Signature of employee. *Firma del empleado.* _____

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

9. Name of employer. *Nombre del empleador.* Nadeane Nielsen
10. Address. *Dirección.* 1585 The Alameda San Jose CA. 95126
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 8/4/17
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 8/4/17
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* ASST OPS MGR 18. Telephone. *Teléfono.* 415.813-4834

**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.

## Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

## *Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad*

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

**Medical Care:** Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

**The Primary Treating Physician (PTP)** is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

**Disclosure of Medical Records:** After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

**Payment for Temporary Disability (Lost Wages):** If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

**Return to Work:** To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

**Atención Médica:** Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

**El Médico Primario que le Atiende-*Primary Treating Physician PTP*** es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

**Divulgación de Expedientes Médicos:** Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

**Pago por Incapacidad Temporal (Sueldos Perdidos):** Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

be temporary or may be extended depending on the nature of your injury or illness.

**Payment for Permanent Disability:** If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

**Supplemental Job Displacement Benefit (SJDB):** If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

**Death Benefits:** If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

**It is illegal for your employer** to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

**You can consult with an attorney**. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

**Regreso al Trabajo:** Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

**Pago por Incapacidad Permanente:** Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

**Beneficio Suplementario por Desplazamiento de Trabajo:** Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

**Beneficios por Muerte:** Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

**Es ilegal que su empleador** le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov.

**Ud. puede consultar con un abogado.** La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

Acrobat outsourcing
Your Hospitality Staffing Professionals

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): Sunnyview Retirement
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: Elizabeth | Middle Initial | Last Name: Jeffery
10. Social Security No.: 565279529
11. Date of Birth: 8/20/58
12. Home Address: No. and Street: 15941 Viewfield Rd
13. Telephone No.: 408 3940225
14. Job Title: Dishwasher
15. Age:
City: Monte Sereno | State: CA | Zip: 95030
16. Dept. assigned to:
17. Sex: ☐ M ☒ F
18. Wages $ 8.14 Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year
Hours Per Day: 8 | 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: 7/28/17

**ACCIDENT**

22. Date of Accident: 8/4/17
Accident Time: AM ☐ PM ☒ 5
Began Shift: AM ☐ 1 PM ☐ 12
23. Location of Accident: Town or City: Cupertino | State: CA
24. Machine or tool involved in the accident: Cart
25. Was it defective? ☐ Yes ☒ No
26. On employer's premises? ☒ Yes ☐ No
If yes, name of department: Dish Room
27. Object or substance directly causing injury:
28. Describe what employee was doing: Pulling a Cart
Was this the employee's regular occupation? ☒ Yes ☐ No
29. Employee Description of Incident: Details:

Cart Ran over toes and made her fall.

**INJURY**

30. Describe the injury and the part of the body injured: Left Arm
**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: 8/5/17
At what weekly wage:
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:
Remained Overnight ☐ Yes ☐ No

**INS.**

38. Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name.
Name in full: Gallagher Bassett | Policy No. LDC4042609 AOS
Signed by: Nadeane Nielsen | Title: | Date: 8/7/17
Employer or Representative

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

**Equal Opportunity is the Law**

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**EMPLOYEE INCIDENT REPORT**

Please print. Submit to HR via E-mail hr@acrobatoutsourcing.com or via Fax (415) 431-1580.

**Accident Information & Location**

Date of Accident: 8/4/17 Time of Accident: 5pm
Date Supervisor notified: _____ Time Notified: 6 pm
Location Name: Sunny View Retirement Department Name: Kitchen

**Employee Information**

Last, First Name: Jeffery Elizabeth
Address: 15941 ~~Technology~~ Viewfield Rd
Social Security Number: 565-27-9529 EE ID: _____
Description:

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: 0 Safeguards/ Safety Equipment used: ☒Yes ☐No ☐Unknown
Body part Injured: Lower Arm Type of Injury: Cut
Number of days missed from work: 0
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:
do not Pull Food CART. I has been descused With Lead to not Put an Employee IN Front of CarT

**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: Elizabeth Jeffery
Date: 8/6/17

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# REFUSAL OF MEDICAL TREATMENT OR OBSERVATION FORM

Employee's Name (Print): Elizabeth Jeffery

Work Location: Supervisor: ROJI

Witness(es): Yes, Nita Romina, ROJI Esha

Nature of Injury/Condition: Food Cart Rolled over Toes, Fell, and Cart Edge Dug in to lower arm

Description of Injury [Body Part(s) Injured]: Lower arm 2inch Cut

Brief Narrative Description of the Incident:
Was told to Pull Food Cart, Instead of Pulling do to Being to Short. (Per Supervisor of duty) Try to Stop Cart it did not Stop and Wheel Rolled over Toes, I fell And Edge of Cart Caught my arm

**I, Elizabeth Jeffery 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) 8/4/17. 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.**

Elizabeth Jeffery 8/4/17

**Employee's Signature** **Date**

# Employee's Report of Incident/Exposure

Employee Name: Elizabeth Jeffery

Job Title: Dish Washer

Supervisor's Name: Roji Esha

Date and time of incident: 5pm

Where did the incident take place? Care Center

Date, time incident Reported: 8/4/17 5pm

Reported to: Roji

Name of Witness(es): [redacted] & Nita Romina

Describe how the incident occurred: Pulling Food Cart to Care Center Try to Stop Cart but Cart did not Stop, It RAN over My Toes Which Made me fall. Cart Edge Cut Lower Arm

What part of the body was injured? Describe the injury in detail.
TOE, only a little numb And lower ARM Cut bleeding and Deep.

What could be done to prevent incidents of this type?
Probably Should have not Been Pulling Cart. But do to Cart being So high It Was Suggested to Pull Cart INSTEAD of Pushing

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

Signature: Elizabeth Jeffery Date: 8/15/17

2/2011

# Supervisor's Report of Incident/Exposure

Employee Name: Elizabeth Jeffery

Job Title: Dishwasher

Supervisor's Name: Roji Esha

Date and time of incident: 8/4/17 at 5:00 p.m

Where did the incident take place? Care Center (whole way) between room # 2 and director office

Date and time incident Reported to you: 8/4/17 at 5:00 PM

Name of Witness(es): Nita Romina

Describe how the incident occurred: I pulled the first Cart to the Care Center and she follow me with the second Cart, I just heared the noise I look back she was setting on the floor with her lower Arm Scratch and took her to Lucy's office to wash her hand.

What actions, events or conditions contributed to this accident?

She is short she can't see the way if she pushing the Cart

What could be done to prevent incidents of this type?

we should have two people to push the Carts or a hight person to push the Carts

Incident Resulted in:

| | | | | | |
|---|---|---|---|---|---|
| | Injury | | First Aid | | Property Damage |
| | Fatality | | Medical Treatment Required | | Work days lost |

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

Signature: [signature] Date: 8/5/17

2/2011

# Witness Statement

Witness Name: Nita Romina
(Please Print)

Date and time of Accident: 8/4/17 5:00PM

In your own words what did you witness or hear:

she was pulling the cart in swing 1 in the Care center at that time and I saw her suddenly fell down and injured her arm (between Room 2 and Director office) Nita Romina 8/5/17

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

Signature: Romina Date: 8/5/17

2/2011

# First Aid Administered

Employee Name: Elizabeth Jeffrey

Date and time of incident: 8/4/17 at 5p.m

Where did the incident take place? Care Center (whole way)

Name/title of person administering First Aid: Roji Esha

Describe what type of First Aid was provided: washed her arm with warm water and dryfit with papertowel and aply hand Sanitizer Gel and cover with Bandages.

What type of injury did the employee experience?

Scratch her lower Arm with the Cat

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

Signature: [signature] Date: 8/4/17

11/2013