ACROBAT OUTSOURCING
TSC GROUP

Employment Application

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 William Kelley Date: 2-25-20

Home Telephone (470) 629-3030 Other Telephone (___) ___

Present Address 4341 Cascade RD SW Atlanta GA 30331

Permanent Address, if different from present address: ___

Email Address William.Kelley96@Gmail.com

EMPLOYMENT DESIRED

Position applying for: Dishwasher / Cook Salary desired: 12hr

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 _____ 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?

___

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							
PM	10pm					10pm	10 pm

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

Form G-4 (Rev. 7/14)

1511004011

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
William Kelley	053-70-6441
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE
4341 Cascade Rd	Atlanta GA 30331

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS
(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: Enter 0 or 1 ..... [ ]
B. Married Filing Joint, both spouses working:
Enter 0 or 1 ..... [ ]
C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 ..... [ ]
D. Married Filing Separate:
Enter 0 or 1 ..... [ ]
E. Head of Household:
Enter 0 or 1 ..... [ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
Yourself: ☐ Age 65 or over ☐ Blind
Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300 ..... $_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:
A. Federal Estimated Itemized Deductions ..... $_____
B. Georgia Standard Deduction (enter one): Single/Head of Household $2,300
Each Spouse $1,500 $_____
C. Subtract Line B from Line A ..... $_____
D. Allowable Deductions to Federal Adjusted Gross Income ..... $_____
E. Add the Amounts on Lines 1, 2C, and 2D ..... $_____
F. Estimate of Taxable Income not Subject to Withholding ..... $_____
G. Subtract Line F from Line E (if zero or less, stop here) ..... $_____
H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above _____
(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ TOTAL ALLOWANCES (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) Read the Line 8 instructions on page 2 before completing this section.
a) I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. Check here ☐
b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is _____. My spouse's (servicemember) state of residence is _____. The states of residence must be the same to be exempt. Check here ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature _____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding. If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, P.O. Box 49432, Atlanta, GA 30359.

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN: _____

EMPLOYER'S WH#: _____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

Name-Based Criminal Background History Record Information Consent/Inquiry Form

I hereby authorize Alto Police Department (Agency/Company) to conduct an inquiry for Acrobat (company) with the purpose(s) listed below and receive any Georgia and/or national criminal background history record information as authorized by state and federal law.

Full Name (print)	William Kelley		
AKA name(s)			
Address	7278 Aubrey Dr Riverdale		
Sex	Race	Date of Birth	Social Security Number
M	Black	04-08-1985	053-70-6441

☐ This authorization is valid for _____ days from date of signature.

☐ I, _____, give consent to the above-named entity to perform periodic criminal history background checks for the duration of my employment.

William Kelley
Signature

2-25-20
Date

Purpose Code Used: (check one that apply)

✓	E - Employment
	N - Working with Elderly
	W - Working with Children

Official use only:

Inquiry: _____ Time of Inquiry: _____ Operator's Initials: _____

The inquiry resulted in the following: (check all that apply)

	No Criminal Record Available
	Criminal Record (Attached/Released)
	No NCIC/GCIC Warrant
	Possible NCIC/GCIC Warrant (List Wanting Agency Below)

Wanting Agency Name: _____

Wanting Agency Telephone: _____

Agency Designee Signature and Title

Date

Revised March 2019

Levy

Non-Profit Associate, Subcontractor and Temporary Employee
HEALTH REPORTING AGREEMENT*

** Applies to all associates of Non-Profit Group, Subcontractor or Temporary Employee*

This form must be completed at least once every 12 months.

The purpose of this agreement is to ensure that you notify the Levy manager or other person in charge when you experience any of the conditions listed so that management can take appropriate steps to prevent the transmission of foodborne illness.

I AGREE TO REPORT TO THE MANAGER OR OTHER PERSON IN CHARGE:

FUTURE SYMPTOMS AND CONDITIONS:

IMPORTANT: It is not necessary to report symptoms, such as diarrhea, associated with chronic medical conditions or illnesses.

1. Diarrhea
2. Vomiting
3. Jaundice (yellowing of the skin and/or eyes)
4. Sore throat with fever
5. Infected cuts or wounds, or lesions containing pus on the hand, wrist, an exposed body part, or other body part and the cuts, wounds, or lesions are not properly covered *(such as boils and infected wounds, however small)*

FUTURE MEDICAL DIAGNOSIS:

1. Any diagnosis of foodborne illness
2. Diagnosis of being ill with Norovirus, Typhoid Fever (Salmonella Typhi), Shigellosis, Salmonellosis, E. coli O157:H7 or other EHEC/STEC infection, Hepatitis A infection or (California only) Amebiasis.

FUTURE HIGH-RISK EXPOSURES:

1. Exposure to or suspicion of causing any confirmed outbreak of foodborne illness
2. A household member diagnosed with a foodborne illness
3. A household member attending or working in a setting experiencing a confirmed outbreak of foodborne illness

I HAVE READ (OR HAD EXPLAINED TO ME) AND UNDERSTAND MY RESPONSIBILITIES UNDER THIS AGREEMENT TO COMPLY WITH:

1. Reporting requirements specified above involving symptoms, conditions, diagnoses, and high-risk exposures
2. Work restrictions or exclusions that are imposed upon me
3. Good hygienic practices

I UNDERSTAND THAT FAILURE TO COMPLY WITH THE TERMS OF THIS AGREEMENT MAY LEAD TO DISCPLINARY ACTION UP TO ANY INCLUDING TERMINATION OF EMPLOYMENT WITH LEVY.

Name (*please print*): William Kelly

Signature: William Kelly Date: 2-25-20

Levy Manager's Signature: _____ Date: _____
(or other person in charge)