



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 David Warner Date: 10/24/19
Home Telephone (678) 698-7655 Other Telephone ()
Present Address 15610th St. Apt 602 Atlanta GA 30309
Permanent Address, if different from present address: _____
Email Address davidwarner41@gmail.com

EMPLOYMENT DESIRED

Position applying for: Bartender, The Danny Server Salary desired: Open

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

NO

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: Open 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							✓

Do you have any vacations or extended leaves planned in the next 12 months? If so, please list dates:
None

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 413 Catherine St Roswell GA 30075

Type of Business Catering Telephone No. (404) 992-0027 Supervisor's Name Paula
Your Position and Duties Bartender and Server

Dates of Employment: From 11/10 To present

Reason for Leaving: On call still working

Name and Address of Employer Mar Lee

Type of Business Bartending Telephone No. (404) 957-8418 Supervisor's Name Mar Lee
Your Position and Duties Bartender

Dates of Employment: From 11/25 To present

Reason for Leaving: On call

Name and Address of Employer Mar Lee Marilyn Jackson

Type of Business Responsibility Telephone No. (404) 815-6263 Supervisor's Name Marilyn Jackson
Your Position and Duties Bartender, Server, Dining Room Attendant


Dates of Employment: From _____ To _____


Reason for Leaving: _____


Name and Address of Employer _____

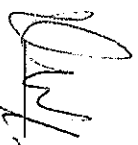
Type of Business _____ Telephone No. (____) _____ Supervisor's Name _____


Please Read Carefully, Initial Each Paragraph and Sign Below

 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.

 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.

 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.

 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.

 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 10/29/19

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 DISCIPLINARY ACTION UP TO ANY INCLUDING TERMINATION OF EMPLOYMENT WITH LEVY.

Name (please print):

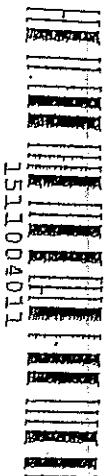
David Mulcare Jr

Signature:

Date: *10/25/10*

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

Date:



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STATE OF GEORGIA EMPLOYEES' WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME DAN WAVE JR.	1b. YOUR SOCIAL SECURITY NUMBER 156-50-8094
2a. HOME ADDRESS (Number, Street, or Rural Route) 150 10th St #602	2b. CITY, STATE AND ZIP CODE Atl. GA 30309

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 14. DEPENDENT ALLOWANCES 1B. Married Filing Joint, both spouses working: 1C. Married Filing Joint, one spouse working: 1D. Married Filing Separate: 1E. Head of Household: 1F. Additional Withholding: 2G. Additional Withholding: 2H. Additional Withholding: 2

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 ☐ BlindSpouse: ☐ Age 65 or over ☐ Blind

2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

A. Federal Estimated Itemized Deductions

B. Georgia Standard Deduction (enter one):

Each Spouse

C. Substantive Line 3 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. Substantive Line F from Line E (if zero or less, stop here)

H. Divide the Amount on Line G by \$3,000. Enter final 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)

(Employer: The letter indicates the tax tables in Employer's Tax Guide)

TOTAL ALLOWANCES (Total of Lines 3-5)

8. EMPLOYER: (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 married 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 state 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.

Employer'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 30369.

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN:

EMPLOYER'S NAME:

EMPLOYER'S FEIN:

EMPLOYER'S NAME:

EMPLOYER'S FEIN:

EMPLOYER'S NAME:

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