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Your Hospitality Staffing Professionals

Name: Judy Heninger

Taborca ID: 49341

Date of Hire: 10/29/18

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

New employee set up

- o E-verify
- o Hire Right EE
- o Hire Right Internal (upload any list A docs)
- o Direct Deposit (Scan to Payroll) and/or Global Cash Card – complete the form & have EE sign
- o Notice to Employee Completed
- o Added to Orientation Time Sheet
- o Attended New Hire Orientation
- o Background Check (Asurint)
- o New Hire List (All fields)
- o Check Taborca Profile (All fields)
- o Upload Resume and Skills Tests (one doc)
- o 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
- o Run new BGC if more than 1 year since last shift worked
- 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: Judy Heninger	Interviewer: Laura
Date: 10/29/2018	Rate of Pay:
Position (s) Applied for: Cashier / concessions	Referred by:

Test Scores					
Server	/35	%	Bartender	/30	%
Prep Cook	/15	%	Barista	/10	%
Grill Cook	/40	%	Cashier	/10	%
Dishwasher	/10	%	Housekeeping	/16	%

Seeking:
- Full-Time
- Part-Time

Relevant Experience & Summary of Strengths

Knife Skills *Total of _____ in Food Service*

Cuisines

1 event staffing
2 cashier / concessions
3

Stations:

1
2
3

needs FHC

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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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 Judy J HeNiNGeR Date: 10-29-18

Home Telephone (___) 408-849-6326 Other Telephone (408) 835-6632

Present Address 260 NaNcy LN San Jose Ca 95127

Permanent Address, if different from present address: ___

Email Address ___

EMPLOYMENT DESIRED

Position applying for: NFL - sports gam **Salary desired:** 8/17.00

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 X 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 CRaigs list Newspaper ☐ Job Fair ☐ Agency ☐ Company Website ☐

Other Web Posting ☐ Other Source ☐

Could you work overtime, if necessary? Yes X No___ If hired, on what date could you start working? 11-1-18

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
	X yes	X yes	X yes	X yes	yes	yes	yes
AM	yes	yes	yes	yes	yes	yes	yes
PM	yes	yes	yes	yes	yes	yes	yes

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 X If yes, when? ___

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

___

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

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

Are you able to perform the essential functions of the job for which you are applying? Yes X No___

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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 San Francisco Fair Chance Ordinance, 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?
Mt Pleasent	San Jose	9e	yes
Do you have any special licenses, certificates or special training? If so please list under "Special".	basic stuff	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:
I do events, catering, food server, Bartender prep cook

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 X ***If so, may we contact your current employer?*** Yes___ No___

Name and Address of Employer Candle Light Resteraunt

Type of Business Resteruant Telephone No. (___) Not in Bussnes Supervisor's Name _____

Your Position and Duties Serve Food, Salad Bar Bartender ~~Keys Club~~ waitress set up

Dates of Employment: From 1995 To 1999 Weekly Pay: Starting $10 00 Ending $ 200 Tips

Reason for Leaving: Sold Bussness

Name and Address of Employer Keys Club

Type of Business Cocktails Telephone No. (408) 923-3772 Supervisor's Name Doug

Your Position and Duties Waitress cash checks, waitress cleaned

Dates of Employment: From 1995 To 1996 Weekly Pay: Starting _____ Ending _____

Reason for Leaving: Sold it to the other Woman

Name and Address of Employer _____

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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: Doug Harrison Telephone No. (408) 923-3772

Address 1260 Nova Ln San Jose Ca 95127

Occupation: AI appliances Relationship: _____ Number of Years Acquainted: 40 yrs

Name: Laurie Rotter Telephone No. (408) 687-7851

Address 165 Lily ann way San Jose 95123

Occupation: Electrician Relationship: Friend Number of Years Acquainted: 30 yrs

Name: Julian Casillas Telephone No. (650) 704-3535

Address 2000 monterey Rd San Jose Ca 95112

Occupation: Capenter Relationship: FRIEND Number of Years Acquainted: 12 yrs

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Please Read Carefully, Initial Each Paragraph and Sign Below

JH 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.

JH 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.

JH 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.

JH 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.

JH 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 Judy J Hennigan Date 10-29-18

NOTICE TO EMPLOYEE

Labor Code section 2810.5

EMPLOYEE

Employee Name: Judy Heminger

Start Date: 10/29/2018

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 San Jose

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

Mailing Address: " "

Telephone Number: 408-483-4271

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): cashier / concessions @ levi's

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):
N/A

(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)

Monica Cherney
(PRINT NAME of Employer representative)

(SIGNATURE of Employer Representative)

10/29/2018
(Date)

Judy Heninger
(PRINT NAME of Employee)

Judy Heninger
(SIGNATURE of Employee)

10-29-18
(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.

M. REZA ROHANI, M.D., F.A.C.S., INC.

2505 SAMARITAN DR.
SAN JOSE CA 95124
408-358-3111

2/5/2020

RE: Judy Heninger

To whom it may concern,

The patient's absence is physician advised due to illness or injury. This certifies that she has been under our care for this problem.
Please excuse Judy from work for the following dates:

January 23, 2020 to February 09, 2020.

Patient is to return to work full duty on February 10, 2020.

Sincerely,

Doctor: M. Reza Rohani, M.D.

Mohammadreza Rohaninejad MD
2505 Samaritan Dr. Ste. 504
San Jose CA, 95124
Tel: 408-358-3111
Fax: 408-358-3114

Sun Life Absence Management Services

Provided by FMLASource®

Facsimile Cover Page

Sun Life Absence Management Services
455 North Cityfront Plaza Drive
Chicago, IL 60611-5322
T: 877.786.3652 F: 877.309.0217/0218
www.sunlife-ams.com

Date: February 03, 2020

To: Dr. Rohani

Fax: 1 (408) 358-3114

Number of pages including cover sheet: 5

From: Sun Life Absence Management Se

The above named employee has requested leave under the FMLA.
Please review and complete the attached documents.

Completed medical certification forms should be returned to
Sun Life Absence Management Services via confidential fax at 877.309.0217/0218.

If you have any questions or concerns you may contact us at 877.786.3652

Employee : Judy Heninger
Employee's Date of Birth : 06/03/1955
Leave Request Number : 2863622

Sun Life Financial®

MEDICAL INQUIRY FORM RELATED TO AN ACCOMMODATION REQUEST

Company Name: The Service Companies, Inc

ADA Leave Request Number: 2863622

Name: Judy Heninger

Your patient has requested time away from work that may qualify under the Americans with Disabilities Act (ADA) as a reasonable accommodation. Please complete this form and **send to the fax number on the last page.** Please avoid using abbreviations when completing this form.

Questions to help determine whether an employee has a disability.

Under the ADA, an employee has a disability if he or she has a physical or mental impairment that substantially limits one or more major life activities or has a record of such impairment. The following questions may help determine whether your patient has a disability.

Does your patient have a physical or mental impairment?

☐ Yes, permanent impairment(s) ☑ Yes, temporary impairment(s) ☐ No

If yes, what is the impairment?

Recent Surgery on 1/23/2020

Answer the following question based on the limitations the patient has when his or her condition is in an active state and what limitations the patient would have if no mitigating or alleviating measures were used.

Mitigating or alleviating measures:

Include regimens of medication, use of medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy.

Do not include ordinary eyeglasses or contact lenses.

Substantial limitations. Does the impairment substantially limit a major life activity? (A major life activity is substantially limited when compared to most people in the general population and/or when it is permanent or long-term.)	☒ Yes	☐ No

If yes, what **major life activity(ies)** (includes **major bodily functions**) is/are affected?

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐ Assistance with managing medications
☐ Breathing	☐ Interacting With Others	☐ Reading	☐ Standing	
☐ Caring For Self	☐ Learning	☐ Seeing	☐ Thinking	☐ Other: (describe)
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping	☒ Working	

Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Other: (describe)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	

Will the impairment, including any residual effects, last for several months? ☐ Yes ☒ No

If the impairment will not several months, please describe the severity of the impairment:

Is there reason to believe that the patient's condition will improve significantly over time, allowing the patient to return to work? ☑ Yes ☐ No

Continued on next page

Part A. Questions to help determine whether an accommodation is needed.

An employee is entitled to an ADA accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested (or a different) accommodation (including those that may mitigate the requested absence) is needed because of the disability. **Talk with your patient about the job functions typically performed to answer the following questions:**

Are job functions impeded? *Do the limitations to major life activities indicated above impede or prevent your patient from performing his/her job functions?* ☒ Yes ☐ No

***If yes*, which job functions are impeded by the limitation?** *Which job functions is the patient unable to perform, or which benefits of employment are inaccessible without accommodation?*

Unable to work at all.

***If yes*, how are job functions impeded by the limitation?** *In what way(s) do the patient's limitation(s) impede his/her ability to perform typical job function(s) or access benefits of employment?*

Recent surgery through ER.

Part B. Questions to help determine effective accommodation options.

The following questions may help determine effective accommodations:

Do you have any suggestions, other than time away from work, regarding possible accommodations to enable performance of job functions? ☐ Yes ☒ No

If "yes", what are they?

If the patient's employer were able to accommodate the above restriction(s) or provide an accommodation to the patient's current role, would the patient be able to return to work? ☐ Yes ☒ No

If so, please list the date your patient could return to work:_____ (mm/dd/yyyy)

How would your suggestions improve the patient's ability to perform job functions?

Will your patient have work restrictions upon returning to work? ☐ Yes ☒ No
If so, please describe the restrictions and indicate how long each restriction will continue:

Continued on next page

Part C. Provide Dates and Frequency for the leave request.

Frequency of Absence:
Will the absences be taken in an uninterrupted block of time **OR** in occasional absences?

☒ Uninterrupted block of time (i.e., continuous) ☐ Occasional absences (i.e., Intermittent or reduced schedule)

For uninterrupted leave, please complete part **C1**. For occasional leave, please complete part **C2**.

Part C1. If this leave is continuous:

A) Start Date: Please indicate start date of continuous leave: 01/23/2020 (mm/dd/yyyy)
End date: On what date do you expect the patient to return to work? 02/10/2020 (mm/dd/yyyy)

How confident are you that the patient will return to work on that date?

☒ **Definitely** will return on the date above
☐ **Very likely** will return on the date above
☐ **Possibly** will return on the date above

OR

☐ I cannot provide an estimate on when my patient will return to work. *If so, please explain:*

_____

B) The date of next scheduled appointment is: 02/05/2020 (mm/dd/yyyy)

Part C2. If this leave is occasional:

☐ **Intermittent Leave:**
Is the patient able to work but needs occasional time off as an accommodation?

Start date for leave or initial appointment date
____ / ____ / _____ (mm/dd/yyyy)

Probable end date for leave
____ / ____ / _____ (mm/dd/yyyy) *or*

☐ Condition is lifelong (check if applicable)

i. Appointments/treatments - *Will the patient need to miss work for appointments or treatments?*

☐ No
☐ Yes - *Estimate treatment schedule:*

Frequency: Up to ____ times per: ☐ week ☐ month ☐ year

Duration for each: Up to _____ ☐ hours ☐ days

Please include the dates of any scheduled appointments and the time required for each appointment:

_____

ii. Flare-ups/Episodes - *Will the patient's condition present in recurring flare-ups or episodes? How often and for how long?*

☐ No
☐ Yes - *Provide estimates:*

Frequency: Up to ____ times per: ☐ week ☐ month ☐ year

Duration for each: Up to _____ ☐ hours ☐ days

☐ **Reduced Schedule Leave:**
Is the patient able to work but needs a FIXED part-time schedule or taking predictable regularly scheduled absences as an accommodation?

Start date of Leave:
____ / ____ / _____ (mm/dd/yyyy)

Probable End Date of Leave:
____ / ____ / _____ (mm/dd/yyyy)

Please indicate the amount of hours the patient will need to **miss** each day. Enter "0" for any days that your patient does work but will not need a reduced schedule.

Su	_____ hours off	☐ Not scheduled to work
M	_____ hours off	☐ Not scheduled to work
Tu	_____ hours off	☐ Not scheduled to work
W	_____ hours off	☐ Not scheduled to work
Th	_____ hours off	☐ Not scheduled to work
F	_____ hours off	☐ Not scheduled to work
Sa	_____ hours off	☐ Not scheduled to work

Continued on next page

Part D. Other questions or comments.

Part E. Health Care Provider's Information.

Signature: _____ Credentials: MD Date: 02/05/2020

Name: M. Reza Rohani, MD Practice: General Surgery

Address: 7505 Samaritan Dr #504 San Jose CA 95124

Phone number: 408 358-3111 Fax number: 408-358-3114

Confidential fax: 877-309-0218

For purposes of California: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.