

Acrobat

OUTSOURCING
Your Hospitality Staffing Professionals

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 Cory MAGRUDER Date: 01/21/19
 Home Telephone (678) 768-5636 Other Telephone ()
 Present Address 806 BEECHWEN ST SW ATLANTA, GA 30310
 Permanent Address, if different from present address: _____
 Email Address SAGAZULU@GMAIL.COM

EMPLOYMENT DESIRED

Position applying for: Any Salary desired: 10 hr or BETTER

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: _____ 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? 01/22/19

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
	<u>ALL</u>						<u>ALL</u>
AM	<u>ALL</u>						
PM	<u>ALL</u>						

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

No

PERSONAL INFORMATION

Have you ever applied to or worked for Acrobat Outsourcing before? Yes No If yes, when? _____

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

If hired, would you have a reliable means of transportation to and from work? Yes No

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

EDUCATION & SKILLS

NAME OF SCHOOL	CITY & STATE	GRADE OR DEGREE COMPLETED	DID YOU GRADUATE?
Auburn University	Montgomery, AL	Bachelor	Yes
Do you have any special licenses, certificates or special training? If so please list under "Special".		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:			

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 LGC (CLEVELAND)

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

Your Position and Duties BRANCH MANAGER

Dates of Employment: From 02/16 To 12/18 Weekly Pay: Starting SALARY Ending CS,000 yr

Reason for Leaving: _____

Name and Address of Employer LGC

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

Your Position and Duties OFFICE MANAGER

Dates of Employment: From 05/13 To 02/16 Weekly Pay: Starting SALARY Ending 35,000 - 50,000 yr

Reason for Leaving: _____

Name and Address of Employer DRAKE STAFFING

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

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Your Position and Duties SERVER / BARTENDER

Dates of Employment: From 03/08 To 04/13 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: _____ Telephone No. (____) _____

Address _____

Occupation: _____ Relationship: _____ Number of Years Acquainted: _____

Name: _____ Telephone No. (____) _____

Address _____

Occupation: _____ Relationship: _____ Number of Years Acquainted: _____

Name: _____ Telephone No. (____) _____

Address _____

Occupation: _____ Relationship: _____ Number of Years Acquainted: _____

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

I hereby authorize Alto Police Department to conduct an inquiry for
Acrobat Agency/Company (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)	<u>Cory MAGRUDER</u>		
AKA name(s)			
Address	<u>37 DELMOOR DR ATLANTA GA 30311</u>		
Sex	Race	Date of Birth	Social Security Number
<u>MALE</u>	<u>BLK</u>	<u>AUGUST 7TH 1978</u>	<u>424-04-6672</u>

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.

Cory Magruder Signature 01/06/20 Date

Purpose Code Used: (check one that apply)

<input checked="" type="checkbox"/> E - Employment
<input type="checkbox"/> N - Working with Elderly
<input type="checkbox"/> W - Working with Children

Official use only:

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

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

<input type="checkbox"/> No Criminal Record Available
<input type="checkbox"/> Criminal Record (Attached/Released)
<input type="checkbox"/> No NCIC/GCIC Warrant
<input type="checkbox"/> Possible NCIC/GCIC Warrant (List Wanting Agency Below)

Wanting Agency Name: _____

Wanting Agency Telephone: _____

Agency Designee Signature and Title _____ Date _____

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): CORY MAGRUDER

Signature: *Cory Magruder* Date: 01/06/20

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



1511004011

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME <i>Cory George MAGRUDER</i>	1b. YOUR SOCIAL SECURITY NUMBER <i>424-04-6672</i>
2a. HOME ADDRESS (Number, Street, or Rural Route) <i>37 Delmore Dr</i>	2b. CITY, STATE AND ZIP CODE <i>ATLANTA, GA 30311</i>

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 **[1]**4. DEPENDENT ALLOWANCES **[2]**

B. Married Filing Joint, both spouses working:

Enter 0 or 1 **[]**

C. Married Filing Joint, one spouse working:

Enter 0 or 1 or 2 **[]**5. ADDITIONAL ALLOWANCES **[]**

(worksheet below must be completed)

D. Married Filing Separate:

Enter 0 or 1 **[]**

E. Head of Household:

Enter 0 or 1 **[1]**6. ADDITIONAL WITHHOLDING **\$ 0**

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 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) **4**
(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 *Cory Magruder* Date **01/04/20**

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.