

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 Shequila Jones Date: April 24, 2019

Home Telephone (404) 573-0977 Other Telephone ()

Present Address 11027 Knotty Pine Place

Permanent Address, if different from present address:

Email Address Shejor36@gmail.com

EMPLOYMENT DESIRED

Position applying for: _____ Salary desired: \$12.00

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 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 Shefia Kenoka 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? 4/29/19

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
AM							
PM							

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 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

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.) _____

Acrobat

outsourcing
Your Hospitality Staffing Professionals

Dates of Employment: From 11/17 To 02/18

Reason for Leaving: new position

Name and Address of Employer _____

Type of Business _____

Telephone No. (____) _____ Supervisor's Name _____

Your Position and Duties _____

Dates of Employment: From _____ To _____

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 P
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: Sherrill Higgins Telephone No: (312) 837-5042

Address: Buggs Rd Duluth Ga

Occupation: Driver /Caterer Relationship: Ex-co worker Number of Years Acquainted: 10

Name: Era Lessington Telephone No. (678) 683-8581

Address: Norcross Ga.

Occupation: Production /Warehouse Relationship: Ex-worker Number of Years Acquainted: 8

Name: Debbie Purify Telephone No. (770) 841-9789

Address: Debatur Ga

Occupation: Camp Director Relationship: Ex-worker Number of Years Acquainted: 15

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): Shephalita Jones

Signature: SDJ Date: 04/24/19

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

1811004012

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME <i>ShirQuita Jones</i>	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route) <i>11027 Knotty Pine Place</i>	2b. CITY, STATE AND ZIP CODE <i>Hampton Ga 30228</i>

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 - 6

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..... <input checked="" type="checkbox"/>	4. DEPENDENT ALLOWANCES <input checked="" type="checkbox"/> <i>12</i>
B. Married Filing Joint, both spouses working: Enter 0 or 1 <input type="checkbox"/>	5. ADDITIONAL ALLOWANCES <input type="checkbox"/> (worksheet below must be completed)
C. Married Filing Joint, one spouse working: Enter 0 or 1 or 2 <input type="checkbox"/>	6. ADDITIONAL WITHHOLDING \$ _____
D. Married Filing Separate: Enter 0 or 1 <input type="checkbox"/>	
E. Head of Household: Enter 0 or 1 <input checked="" type="checkbox"/>	

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: <input type="checkbox"/> Age 65 or over <input type="checkbox"/> Blind	Spouse: <input type="checkbox"/> Age 65 or over <input type="checkbox"/> Blind	Number of boxes checked _____ x 1300\$ _____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:		
A. Federal Estimated Itemized Deductions (If Itemizing Deductions).....\$ _____		
B. Georgia Standard Deduction (enter one): Single/Head of Household \$4,600 Each Spouse \$3,000 \$ _____		
C. Subtract Line B from Line A (If zero or less, enter zero).....\$ _____		
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) <i>A/E</i>	TOTAL ALLOWANCES (Total of Lines 3 - 5) <i>4</i>
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(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 *B. Jones*Date *04/24/19*

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.