



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 Buchea Walker Date: 11/11/14
Home Telephone (404) 453-8125 Other Telephone (404) 453-8125

Present Address 431 N. Piedmont Rd.

Permanent Address, if different from present address:

Email Address YlmaelWalker@yahoo.com

EMPLOYMENT DESIRED

Position applying for: Sex Toy Salary desired: \$12/hr

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	Open	Open	Open	Open	Open	Open	Open
PM	Open	Open	Open	Open	Open	Open	Open

Do you have any vacations or extended leaves planned in the next 12 months? If so, please list dates: NO

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 Langcroft Bestfriend road, Stone Mountain

Type of Business Box Telephone No. (110) 444-7444 Supervisor's Name Penick
Your Position and Duties Warehouse
Box packer, lift boxes daily.

Dates of Employment: From 11/19 To current

Reason for Leaving: _____

Name and Address of Employer Levy Restaurants. (Carnegie Ward Congress Center)

Type of Business Food Telephone No. (404) 218-4324 Supervisor's Name John Becker
Your Position and Duties Server Guest meals, carry trays, as well as
businesses.

Dates of Employment: From 1/2016 To 1/2018

Reason for Leaving: Better opportunity.

Name and Address of Employer Sunrise Senior Living

Type of Business Assisted Living Telephone No. (678) 417-3033 Supervisor's Name Linda Howell
Your Position and Duties Caregiver, Assist residents with ADLs,

Dates of Employment: From 1/2016 To 10/19

Reason for Leaving: Needed a Lunch

Name and Address of Employer _____

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

Please Read Carefully, Initial Each Paragraph and Sign Below

PN

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.

PN

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.

PN

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.

PN

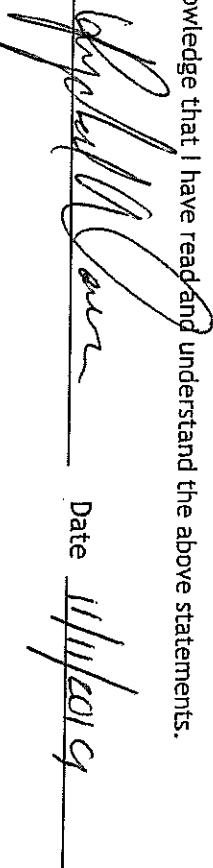
I understand that if selected for hire, it will be necessary for me to provide satisfactory evidence of my identity and legal authority to work in the United States, and that federal immigration laws require me to complete an I-9 form in this regard within three days of my hire date.

PN

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

11/1/2019

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

I hereby authorize Alto Police Department 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)	<u>Ruchael Walker</u>		
AKA name(s)	<u>N/A</u>		
Address	<u>437 Wildwood Glen</u>		
Sex	Race	Date of Birth	Social Security Number
<u>F</u>	<u>0</u>	<u>03/02/1914</u>	<u>044-92-4512</u>

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

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

Signature Ruchael Walker Date 11/11/2019

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 _____

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): Levy Manager

Signature: Levy Manager

Levy Manager's Signature: _____ Date: 11/11/19
(or other person in charge) Date: _____

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STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME

RUCKEY WAKER

2a. HOME ADDRESS (Number, Street, or Rural Route)

437 Wildwood Glen

2b. CITY, STATE AND ZIP CODE

Stone Mountain 30083

PLEASE READ INSTRUCTIONS OR REVERSE SIDE BEFORE COMPLETING LINES 3-8

(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

(Worksheet below must be completed)

5. ADDITIONAL ALLOWANCES

(Worksheet below must be completed)

6. ADDITIONAL WITHHOLDING

(Worksheet below must be completed)

3. MARITAL STATUS

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:

Yourself Age 65 or over BlindSpouse Age 65 or over BlindNumber of boxes checked x 1300

2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

A. Federal Standard Itemized Deductions

B. Georgia Standard Deductions (Enter one):

Each Spouse Standard or Household \$2,300C. Subtract Line B from Line A \$1,500D. Allowable Deductions to Federal Adjusted Gross Income \$E. Add the Amounts on Lines 1, 2C, and 2D \$F. Subtract or 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 \$2,000. 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 G-3 (Marital Status A, B, C, D, or E) (Employee. The letter indicates the tax tables in Employer's Tax Guide) TOTAL ALLOWANCES (Total of Lines 3-5)

8. EXEMPT: (Do not complete Lines 3-7 if claiming exemption from Line 8 instructions on page 2 because this section does not apply to you.)

I. 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 D. I claim that I am not subject to Georgia withholding because I meet the conditions set forth under the Service's Georgia Resident Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is . My spouse's (spouse's name) 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 claimed on this Form G-4. Also, I am not using my employer to deduct per pay period the additional amount listed above.

Employee's Signature Wanda M. WakerDate 1/1/10

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

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

EMPLOYER'S NAME

EMPLOYER'S FEIN