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 MyKayla Marshall Date: 1/22/2020

Home Telephone (404) 702 2490 Other Telephone (404) 454 0133

Present Address 2630 Shadowbrook dr 30034

Permanent Address, if different from present address: _____

Email Address MyKaylamarshall90@gmail.com

EMPLOYMENT DESIRED

Position applying for: Cashier / housekeeping Salary desired: $10 - $11 hour

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?

February 3, 2020

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:

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 Druid Hill Golf Club

Type of Business House Keeping Telephone No. (___) _____ Supervisor's Name Minnie Thompson
Your Position and Duties Pool Attendant

Dates of Employment: From April 2018 To Sep. 2018

Reason for Leaving: Season over.

Name and Address of Employer Druid Hill Golf Club

Type of Business House Keeping Telephone No. (___) _____ Supervisor's Name Minnie Thompson
Your Position and Duties pool attendant

Dates of Employment: From April 2019 To Aug. 2019

Reason for Leaving: Season over

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: _____

Name and Address of Employer _____

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

Please Read Carefully, Initial Each Paragraph and Sign Below

MM 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.

MM 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.

MM 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.

MM 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.

MM 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 [signature] Date 1/22/2020

Form G-4 (Rev. 7/14)

1511004011

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
Mykayla DeAnna Marshall	671 070 567
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE
2630 Shadowbrook dr	Decatur Ga. 30034

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]
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 [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

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 ☐ Blind
Spouse: ☐ 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) _____
(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 _____ 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 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.

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

Name (*please print*): MyKayla Marshall

Signature: MyKayla Marshall Date: 4/22/2020

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