Construction Group Staffing

8712 E. Via De Commercio Ste #2
Scottsdale, AZ 85258
Phone: (480) 219-9795
FAX: (480) 219-9709
payroll@constructiongroupstaffing.com

Application Information

Social Security #: _____ **Today's Date**: _____ **Desired Salary**: _____

Full Name: _____ **Date Available**: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Phone: _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____

Position Applied for: _____

Are you a citizen of the United States? ☐ Yes ☐ No **If no, are you authorized to work in the U.S.?** ☐ Yes ☐ No

Have you ever worked for this company? ☐ Yes ☐ No **If yes, when?** _____

Have you ever been convicted of a felony? ☐ Yes ☐ No

If yes, explain: _____

_____

A CONVICTION RECORD WILL NOT NECESSARILY EXCLUDE YOU FROM CONSIDERATION. THIS INFORMATION WILL BE USED ONLY FOR JOB-RELATED PURPOSES AND ONLY TO THE EXTENT PERMITTED BY LAW.

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Previous Employment

Company: _____ **Phone:** _____

Address: _____ **Supervisor:** _____

Job Title: _____ **Salary**: $ _____

Responsibilities: _____

From: _____ **To:** _____ **Reason for Leaving**: _____

May we contact your previous supervisor for a reference? ☐ Yes ☐ No

Company: _____ **Phone:** _____

Address: _____ **Supervisor:** _____

Job Title: _____ **Salary**: $ _____

Responsibilities: _____

From: _____ **To:** _____ **Reason for Leaving**: _____

May we contact your previous supervisor for a reference? ☐ Yes ☐ No

Company: _____ **Phone:** _____

Address: _____ **Supervisor:** _____

Job Title: _____ **Salary**: $ _____

Responsibilities: _____

From: _____ **To:** _____ **Reason for Leaving**: _____

May we contact your previous supervisor for a reference ☐ Yes ☐ No

Disclaimer and Signature

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed; falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws.

Signature: _____ **Date:** _____

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I authorize Construction Group Staffing to initiate electronic credit entries, and if necessary, debit entries and adjustments for any credit entries in error to my:

___Checking Account

___Savings Account

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have canceled it in writing.

Name (Please Print) Social Security Number

Signature Date

TO ENROLL IN DIRECT DEPOSIT PLEASE FILLOUT THE FOLLOWING INFORMATION:

Financial Institution

Financial Institution Address

City **State** **Zip**

Financial Routing/Transit Number **Account Number**

PLEASE ATTACH A VOIDED CHECK (NOT A DEPOSIT SLIP)

Signature Date

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Equal Employment Opportunity Form

Applicant Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Social Security Number: _____

Position Applied for: _____

Voluntary Information

This information is being requested in accordance with federal regulations. The information is voluntary and will not be used when considering you for employment with our company.

Racial or Ethnic Group

- ☐ American Indian/Alaskan
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ White/Caucasian
- ☐ Other

Gender

- ☐ Female
- ☐ Male

Military Service

- ☐ Pre-Vietnam Era
- ☐ Vietnam Era
- ☐ Post-Vietnam Era
- ☐ Disabled Veteran

How did you hear about this position?

- ☐ Newspaper
- ☐ Company Employee
- ☐ Professional Publication
- ☐ Job Fair
- ☐ Placement Office
- ☐ Web Site
- ☐ Other

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Employee Handbook Acknowledgement

I have read and agree with the Employee Handbook associated with this application. I understand that it applies to me and my position held at Construction Group Staffing I acknowledge that I have a duty to thoroughly familiarize myself with its contents. I further understand that Construction Group Staffing may rescind, change or add to any policies or practices described in the Employee Handbook from time to time, in our sole discretion with or with our prior notice.

I also understand that I am fully responsible for completely reading and understanding this handbook. I agree that this handbook replaces and all prior handbooks, policies, rules and procedures discussed in this handbook. I understand that I can ask my manager at any time for any information on any subject covered in this handbook. I also agree that I have received a copy of this handbook.

I know that my employment is for no specific time and is at all times “AT-WILL”, and that I may end my employment at any time with, or without cause with or without notice. Likewise, Construction Group Staffing may end my employment at any time with or without cause, with or without notice and without liability. I will not rely on any statements contained in this handbook as either creating or attempting to create any type of employment contract with Construction Group Staffing.

I understand that Construction Group Staffing alone has the responsibility to manage its work site, select its clients, recruit, hire, set schedules and assign and direct the work of employees. I agree that Construction Group Staffing, alone has the responsibility to reclassify employees, establish job definitions, set and enforce rules and regulations, discipline employees (including suspension or discharge). Construction Group Staffing retains the unrestricted discretion, to make any and all decisions concerning my employment, including decisions about my job description, job responsibility and change in my compensation (this includes increases and decreases).

Safety:

I understand that I will have, and am responsible for bringing all the required PERSONNEL PROTECTIVE EQUIPMENT to all job sites, which this includes but is not limited to, a hard hat, a safety vest, glasses, ear plugs, gloves, as well as work boots. This consists of any of my personally owned PPE or PPE supplied by Construction Group Staffing for which I might have been equipped with prior to employment. If you do not have the required PPE for a specific job, you must inform us so that we can you the required PPE. Any additional safety equipment or tools supplied by Construction Group Staffing will be deducted from employee’s first paycheck (Unless otherwise noted).

Earned Sick Time:

I have read and understand Construction Group Staffing's earned sick time policy which was provided to me in the Employee Handbook

Ending of Assignment and/or Position Full-filled/Released:

If at any time your assignment ends with a client, it is your responsibility to inform Construction Group Staffing IMMEDIATELY so Construction Group Staffing can schedule your next assignment. Failure to report will be taken as VOLUNTEER RESIGNATION.

Signature: _____ **Date:** _____

Construction Group Staffing

Post-Offer Medical Questionnaire

(To be maintained in a separate file of confidential medical records)

IF THERE IS ANY QUESTION OR STATEMENT ON THIS FORM THAT YOU DO NOT UNDERSTAND, ASK FOR ASSISTANCE FROM THE PERSON INTERVIEWING YOU.

Employee Name_____ Social Security # ---------- _____

Date of Birth_____/_____/_____ Height _____ Weight _____
Month Day Year

By completing this form, I am verifying that the above named company has already presented a conditional job offer to me.

Circle the appropriate yes or no and complete the appropriate blanks.

Have You Ever Had?			Have You Ever Had?		
Yes	No	Asthma, Allergies, Pulmonary Disease	Yes	No	Knee problems
Yes	No	Migraine headaches	Yes	No	Diabetes
Yes	No	A head injury	Yes	No	Color blindness
Yes	No	Fainting spells or dizziness, seizures	Yes	No	Loss of sight of one or both eyes
Yes	No	Swelling of the legs or ankles	Yes	No	Cardiovascular disorder, heart trouble
Yes	No	Skin rashes or Eczema	Yes	No	Tuberculosis
Yes	No	Joint pains or Arthritis	Yes	No	Hemophilia
Yes	No	Cancer	Yes	No	Chronic infection of bone
Yes	No	Repetitive Motion Disorder, Carpal Tunnel Syndrome, Tendonitis	Yes	No	Depression

---

Yes No Do you have partial loss of hearing?
Yes No Have you ever had an audiogram (hearing test)? If yes, results _____
Yes No Do you need glasses to read or for distance?
Yes No Any broken bones? Which bones?_____When? _____
Yes No High blood pressure? If yes, do you take medication to control high blood pressure? Yes No
Yes No Any serious injuries? Month_____Year_____Nature of the injury _____
Yes No A hernia or rupture? Month_____ Year _____
Yes No Any neck pain, injury or problems? Month_____Year _____
Yes No Injured back? Month_____ Year _____
Yes No Surgery? Month_____ Year_____Type? _____
Yes No Ever refused surgery? If yes, why? _____
Yes No Injured shoulder? If yes, which one_____Month_____Year _____
Yes No Injured knee? If yes, which one_____Month_____Year _____

Have You Ever Had?

Yes No An allergic reaction to any drugs? Which drugs? _____
Yes No Partial loss of uncorrected vision of more than 75 percent bilaterally?
Yes No Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months?
Yes No Any permanent condition that constitutes 20 percent impairment of a foot, leg, hand, or arm, or of the body as a whole?
Yes No Do you or have you within the past year participated in recreational drug use?
Yes No Have you ever participated in a drug abuse treatment program?
Where? _____
Yes No Do you currently take any prescription medications? If so, what? _____
Yes No Do you have any condition or have you sustained any injury that would have an effect on your capacity to perform the duties of this position without reasonable accommodations?

Estimate the number of workdays you have lost in each of the past two years. _____ _____

Please list the name of any doctors you have seen during the past two years. List your family doctor first.

_____

Yes No Have you ever been hurt on the job or filed a worker's compensation claim in the past?

If yes, how many times?_____ What Years? _____ _____ _____ _____

Please provide pertinent facts to every previous ailment or injury contributing to impairment, as well as all previous worker's compensation claims in the space provided:

_____

_____

Have You Ever Been Refused Employment or Unable to Hold a Job Because of?

Yes No Sensitivity to dust
Yes No Other medical reasons? Please Specify below.
Yes No Inability to perform certain motions
Yes No Inability to assume certain positions

_____

*****OUR WORKERS COMPENSATION INSURANCE CARRIER MAY CHECK FOR PREVIOUS CLAIMS BY NAME AND SOCIAL SECURITY NUMBER. IF YOU HAD A PREVIOUS CLAIM OR INJURY, AND FAIL TO MAKE US AWARE OF IT, YOU MAY BE LEGALLY DENIED BENEFITS IN THE EVENT OF A NEW INJURY BY OPERATION OF THE LANDMARK RYCROFT RULING. FOR YOUR OWN PROTECTION AND APPROPRIATE MEDICAL CARE, PLEASE MAKE US AWARE OF ANY PREVIOUS INJURIES.*****

_____ _____
Signature Date

_____ _____
Company Representative Date

Construction Group Staffing

EMPLOYEE DRUG AND ALCOHOL SCREEN CONSENT FORM

I,_____, hereby understand that, as a condition of my employment, I may be subject to drug and/or alcohol testing for any of the following reasons:

- Pre-employment
- Post-Hire
- Post-Accident
- For Cause or Suspicion
- Random
- Promotion and/or Job Transition

I understand that when I am requested to produce a specimen for drug and/or alcohol testing, I must comply immediately. I also understand that a positive drug or alcohol test or that my refusal to produce a specimen upon request can be cause for termination. I further understand that the illegal use, sale, possession, or distribution of drugs or alcohol, as well as any illegally obtained prescription medication, is a violation of company policy and is cause for immediate termination.

I understand and accept the terms of this agreement as a condition of my employment. _____
(Employee Initials)

RELEASE OF CRIMINAL RECORDS

I, the undersigned, do hereby authorize the above company to examine any and all criminal records and arrests on file in the counties in the State of Arizona or any other state, IF NEEDED. In doing so, I understand that I am waiving my right of confidentiality concerning my criminal history. I also Herby release any parties concerned from any actions whatsoever, arising out of or relating to the release of the requested information.

At this time, would your Criminal / Background History Report show any derogatory information at all?
(Circle One.) Yes No

Answering "yes" will NOT automatically disqualify you from employment consideration.

If yes, please explain in detail. _____

_____

_____

Signature _____ **Date** _____

Print Name _____ **Social Security Number** _____

Driver's License Number _____ **Street Address** _____

City _____ **State** _____ **Zip** _____

VSI **2941200-AFU** | OFFICE USE ONLY | LOCATION _____ | Rehire Date ___/___/_____

ENROLLMENT FORM

ESC/MEC 4US P1DM v20.1

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name	Home Phone	
Social Security #	Date of Birth / /	Gender M F
Address		Apt. #
City	Zip	State

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare benefits?
☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for all the benefits in Section C will be identical. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only ☐	**$22.76**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + Child(ren) ☐	**$37.78**	**$14.58**	**$6.54**	**$0.90**	
Employee + Spouse ☐	**$43.24**	**$10.80**	**$4.84**	**$0.90**	
Employee + Family ☐	**$57.58**	**$20.52**	**$9.20**	**$1.80**	
NO to ALL Benefits ☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of NH, HI, or PR. [2] STD is not available to persons who work in CA, HI, NJ, NY, or RI.

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82941200-M-AFU | **Direct Payment Monthly Rates**

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

☐ **$58.19** Employee Only ☐ **$65.79** Employee + Child(ren) ☐ **$71.00** Employee + Spouse ☐ **$80.87** Employee + Family

☐ **NO** to MEC Wellness/Preventive

F. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage.

DATE _/ /__ __ __ _ ▶ **SIGNATURE**

Form **W•4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

@20

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov.*
City or town, state, and ZIP code		

(c) D **Single or Married filing separately**
D **Married filing jointly** (or Qualifying widow(er))
D **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs .

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* tor most accurate withholding for this step (and Steps 3-4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . ▶ D

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . ▶ $ _____

Add the amounts above and enter the total here . 3 $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here 4(b) $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** 4(c) $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ **Employee's signature** (This form is not valid unless you sign it.) ▶ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

► START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP