James McMinn Inc.

Application Packet

- **Must attach a copy of Driver's License and Social Security Card.**

___ Mail Check Home

Mailing Address _____

_____

___ Pick Check Up From Office

For Office Use Only

Position Hired For:

___ Operator

_____ *If Operator, please note what type of equipment*

___ Labor

___ Grade Checker

___ Mechanic/Yard

___ Other

Rate of Pay _____

Date of Hire _____

Start Date _____

Initial of Employee doing Hiring _____

James McMinn, Inc.

APPLICATION FOR EMPLOYMENT

An Equal Opportunity Employer

We do not discriminate on the basis of race, color, religion, national origin, sex, veteran status, disability, or other protected statuses. It is our intention that all qualified applicants are given equal opportunity and that selection decision be based on job-related factors.

Each question should be fully and accurately answered. No action can be taken on this application until all questions have been answered. Use blank paper if you do not have enough room on this application. PLEASE PRINT, except for signatures on back of application, in reading and in answering the following questions, be aware that none of the questions are intended to imply illegal preferences or discrimination based upon non-job-related information.

Job Applied For_____ Today's Date_____

Are you seeking: Full-Time _____ Part-Time _____ Temporary _____

How did you hear about this job? _____

When could you start work?

_____

_____

_____ _____

Last Name First Name Middle Name Telephone Number

_____

Present Street Address City State Zip Code

Are you 18 years of age or older?.....Yes___ No___

(If you are hired, you may be required to submit proof of age.)

Social Security Number_____

If hired, can you furnish proof you are eligible to work in the U.S.?.....Yes___ No___

_____

Have you ever applied here before? … Yes___ No___ If yes, when? _____

Were you ever employed here?..... Yes___ No___ If yes, when? _____

Have you ever been convicted of any law violations (except a minor traffic violation)? Yes___ No___

If yes, give details_____

_____

(A "yes" answer does not automatically disqualify you from employment, since the nature of the offense, date, and the job which you are applying will be considered.)

Special Skills

What skills or additional training do you have that are related to the job for which you are applying?_____

_____

What machines or equipment can you operate that are related to the job for which you are applying?_____

_____

For Driving Jobs Only: Do you have a valid driver's license:…… Yes___ No___

Driver's License Number_____ Class of License_____

Have you had your driver's license suspended or revoked in the last 3 years?... Yes___ No___

If yes, give details_____

List professional trade and offices held.

(Exclude labor organizations and memberships which reveal race, color, religion, national origin, sex, age, disability or other protected status.)

_____

_____

_____

_____

_____

Affidavit

PLEASE READ EACH STATEMENT CAREFULLY BEFORE SIGNING

I certify that all information provided in this employment application I true and complete. I understand that any false information or omission may disqualify me from further consideration for employment and may justify my dismissal if discovered at a later date.

I understand I will be required to successfully pass a drug screening examination and I hereby consent to the company's drug policy.

I UNDERSTAND THAT THIS APPLICATION OR SUBSEQUENT EMPLYMENT DOES NOT CREATE A CONTRACT OF EMPLYMENT NOR GUARANTEE EMPLOYMENT FOR ANY DEFINITE PERIOD OF TIME.

I have read, understand and by my signature consent to these statements.

Signature: _____ Date: _____

This application for employment will remain active for a limited time. Ask the organization representative for details.

EMPLOYEE INFORMATION SHEET

Name: _____

Address: _____

_____

D.O.B.: _____

Home Telephone: _____

Alternative Number: _____

In Case of Emergency

Contact #1

Name: _____ Relationship: _____

Address: _____

_____

Telephone: _____

Contact #2

Name: _____ Relationship: _____

Address: _____

_____

Telephone: _____

SUBSTANCE ABUSE POLICY

I. PURPOSE

To promote and establish a safe working environment for all employees, contractors, subcontractors, and the general public.

II. STATEMENT OF POLICY:

Narcotics, illegal drugs, controlled substances, and alcohol of any kind are hereinafter referred to collectively as "prohibited Substances."

The use, manufacture, sale, distribution, or possession of prohibited substances while on the job, on company property, or at a company job site is strictly prohibited and shall result in termination.

Employees are prohibited from being at work or going to and from work, while under the influence of prohibited substances. Any employee who demonstrates impairment or is suspected of being under the influence or prohibited substances may be required to submit to testing and/or examination as a condition of continued employment.

Any employee using a prescribed or over the counter drug or medication should consult a physician and take all other steps reasonable and necessary to insure that any such drug or medication will not impair their ability to work safely. Every employee is responsible for notifying the company immediately if any prescribed drug or medication is adversely affecting the employees ability to safely perform his/her job duties and responsibilities.

Employee acknowledges that this Substance Abuse Policy memorandum does not create any rights of continued employment or in any way change the current at will status of employee's employment.

The company reserves the right to altar, amend or change this Substance Abuse Policy from time to time at the company's sole discretion.

Employee acknowledges that he/she has the option to not sign this Substance Abuse Policy memorandum and, instead, seek employment elsewhere.

Employee acknowledges that the company, at its sole discretion, may require employee to submit to testing or examination for possible substance abuse or violation of the policy, as a condition to continue employment.

Employees acknowledge that he/she has thoroughly read this entire Substance abuse Policy memorandum and agrees to all of its terms and conditions.

_____ _____

(Signature) (Date)

_____

(Print)

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	**7**	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A **Identity and Employment Authorization**	**OR**	**List B** **Identity**	**AND**	**List C** **Employment Authorization**
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions*.)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy):*

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

NOTICE TO EMPLOYEE

Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: James McMinn Inc. (JMI)

Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? ☐ Yes ☑ No

Other Names Hiring Employer is "doing business as" (if applicable):

None

Physical Address of Hiring Employer's Main Office:

21801 E. Barton Rd. Unit B Grand Terrace, CA 92313

Hiring Employer's Mailing Address (if different than above):

Same as above

Hiring Employer's Telephone Number: 909-514-1231

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: N/A

Physical Address of Main Office: N/A

Mailing Address: N/A

Telephone Number: N/A

WAGE INFORMATION

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

Rate by (check box): ☐ Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece rate ☐ Commission

☐ Other (provide specifics): _____

Does a written agreement exist providing the rate(s) of pay? (check box) ☐ Yes ☐ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? ☐ Yes ☐ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):

_____

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: _____

WORKERS' COMPENSATION

Insurance Carrier's Name: Travelers Indemnity Insurance
Address: PO Box 6510 Diamond Bar, CA 91765-8510
Telephone Number: 800-238-6225
Policy No.: DTJUB8G52534A16
□ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _____

PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
   1. requesting or using accrued sick days;
   2. attempting to exercise the right to use accrued paid sick days;
   3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
   4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: *(Check one box)*

□ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
□ 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
□ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.
□ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption):_____

ACKNOWLEDGEMENT OF RECEIPT
(Optional)

_____	_____
(PRINT NAME of Employer representative)	(PRINT NAME of Employee)
_____	_____
(SIGNATURE of Employer Representative)	(SIGNATURE of Employee)
_____	_____
(Date)	(Date)

The employee's signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.

TRAVELERS

Your Workers' Compensation Benefits

CALIFORNIA

This form should be given to all newly hired employees in the State of California. Its content applies to industrial injuries on or after January 1, 2013.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job, or are a victim of a workplace crime. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures to a harmful condition (such as hurting your wrist from doing the same motion over and over).

Workers' compensation benefits include:

Medical Care: Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. Physical therapy, occupational therapy and chiropractic visits may be limited to 24 each.

Temporary Disability Benefits: Payments if you lose wages while recovering. For most injuries after April 18, 2004, temporary disability benefits are limited to 104 weeks within 5 years from your date of injury. Filing a timely Employment Development Department claim may result in additional state disability benefits when TTD benefits are terminated, delayed or denied.

Permanent Disability Benefits: Payments if your injury causes a permanent disability. Once your injury stabilizes, your treating physician may find permanent disability, depending upon your level of recovery. The amount of permanent disability found by your doctor will be rated by your claims administrator according to your age and occupation in order to determine the percentage and corresponding dollar amount of permanent disability due. These amounts are set by state law. You have the right to obtain a state disability rating or appeal a rating.

Return to Work Program: If you experience a permanent earnings loss as a result of your injury and your permanent disability benefits are determined to be disproportionately low, you may qualify for additional monies from the Department of Industrial Relation's Return to Work Fund. Contact the Department of Industrial Relations at: www.dir.ca.gov/ to learn more about this additional benefit.

Supplemental Job Displacement Vouchers: If your injury causes you to miss time from work and results in permanent disability, you may receive a supplemental job displacement voucher if your employer has not offered modified, alternative or regular employment within 60 days of receipt of the doctor's medical report indicating you have made a maximum medical recovery. The voucher is for reimbursement of education-related costs and is capped at $6,000.00, If you receive a voucher as a result of your injury, you have two years from the date you are furnished the voucher or five years from your date of injury (whichever occurs later), to request reimbursement for qualifying expenditures.

Death Benefits: Paid to dependents of a worker who dies from a work-related injury or illness. Burial expenses are also provided, with the maximum amount allowed dependent upon the date of injury.

Temporary disability, permanent disability, and death benefits are all payable at a rate based on 2/3 of your average weekly wage, and subject to state minimum and maximum amounts in effect on your date of injury. These benefits are paid every two weeks while you are eligible.

Voluntary, off duty, recreational, social or athletic activities may not be covered under workers' compensation.

If you get hurt:

Get Medical Care. If you need first aid, contact your employer. If you need emergency care, call for help immediately.

Report Your Injury. Report the injury immediately to your supervisor. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury, and must also authorize treatment within one working day after you have returned a signed and completed copy of the form. The statute of limitations for filing a workers' compensation claim is one year from the date of injury or, if resulting from repeated exposures, one year from when you realized or should have realized that your job caused the injury.

See Your Treating Physician. Your primary treating physician is the doctor with overall responsibility for treating your injury or illness. He or she is charged with maintaining the continuity of your care, as well as initiating referrals to specialists. If your employer has an approved Medical Provider Network (MPN), they may be able to limit your choices of treating physicians retain medical control, and require you to treat with an MPN physician from the onset. (An MPN is a selected network of healthcare providers who provide treatment to workers injured on the job. See your employer for more information on your MPN.) Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. If your employer does not have an approved MPN and you wish to change doctors in the first 30 days after reporting your claim, your claims administrator must select a new physician within five days of your request.

If you have provided your employer with the name of your personal physician before your injury and have group health insurance at the time of injury, you may see your personal physician for treatment even if your employer has an approved MPN. Your personal physician must be a general practitioner or a board-certified or board-eligible internist, pediatrician, obstetrician- gynecologist, family practitioner, or multi-specialty medical group of doctors of medicine or osteopathy, and must have treated you and maintained your medical history and records before your work injury and must also agree to treat you for a work-related injury or illness. If your employer does not have an approved MPN and you gave your employer the name of your personal chiropractor or acupuncturist in writing before you were injured, you may switch to the chiropractor or acupuncturist upon request. If you still need medical care after 30 days, you may be able to switch to a doctor of your own choice.

For your convenience, optional forms to predesignate your personal physician or multi-specialty medical group of doctors of medicine or osteopathy are attached to this document. Also attached, are forms to predesignate your personal acupuncturist or chiropractor if your employer does not have a medical provider network in place. By law, chiropractors are not allowed to be the treating physician after 24 visits.

Discrimination: It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If your employer has been found to discriminate, you may be entitled to job reinstatement with back pay, increased compensation, and costs and expenses. You may also have additional rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-3362. You can get free information from a state Division of Workers' Compensation Information & Assistance Officer. Hear recorded information and a list of local offices by calling toll-free **(800) 736-7401** or learn more online at: **http://www.dir.ca.gov** .

If medical care is not being provided by your employer you have several options. First, contact your claims administrator to find out the status of your claim. If you have given your employer a completed and signed claim form but your claim has been delayed for investigation, your employer is still required to authorize treatment, up to $10,000.00, during the delay. If the claim has not been accepted yet and your medical costs have exceeded the statutory $10,000.00 cap, you can go to your group health plan for care, find a doctor, clinic or hospital that will bill the claims administrator directly, or use public health services.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it.

Your Workers' Compensation Insurance Company is **The Travelers Indemnity Company**.

You can also look up your insurance carrier at the WCIRB online lookup: https://www.caworkcompcoverage.com/

You can obtain free information from an Information and Assistance Officer of the state Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. A list of Information and Assistance offices can be found at the end of this pamphlet to help you locate the I&A office nearest you. You may also go to the DWC web site at: **http://www.dir.ca.gov** for further information.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at: **http://www.californiaspecialist.org**. You may get a list of attorneys from your local information and assistance officer or look in your yellow pages.

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury, you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work- related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ **(name of employer)**
If I have a work-related injury or illness, I choose to be treated by:
(Name of Doctor, M.D., D.O., or medical group)

_____

(Street address, city, state, zip code) _____

(Telephone number) _____

Employee Name (please print): _____

Employee's Address: _____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee's Signature _____ **Date:** _____

Physician: I agree to this Predesignation.

Signature: _____ **Date:** _____
(Physician or designated employee of the physician or medical group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783
(Optional DWC Form 9783 Effective date July 1, 2014)

Predesignation of Personal Physician; Reporting Duties of the Primary Treating Physician
Regulations 8 C.C.R. section 9780, et seq. (Approved 02/12/2014)

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004, or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(Telephone number)

Employee Name (please print): _____

Employee's Address:

_____

Employee's Signature_____**Date:**_____

Title 8, California Code of Regulations, section 9783.1
(Optional DWC Form 9783.1 Effective date July 1, 2014)

Predesignation of Personal Physician; Reporting Duties of the Primary Treating Physician
Regulations 8 C.C.R. section 9780, et seq. (Approved 02/12/2014)

Contact the information & assistance unit

- By phone at 1-800-736-7401: For recorded information that helps injured workers, employers and others understand
- California's workers' compensation system, and their rights and responsibilities under the law.
- By attending a workshop for injured workers
- By calling or going in person to a local Information & Assistance Unit office:

Anaheim 1065 N. PacifiCenter Drive Anaheim, CA 92806 (714) 414-1801	**Oakland** 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861	**San Diego** 7575 Metropolitan Drive, Suite 202 San Diego, CA 92102-4424 (619) 767-2082
Bakersfield 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514	**Oxnard** 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93030 (805) 485-3528	**San Francisco** 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020
Eureka 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723	**Pomona** 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568	**San Jose** 100 Paseo de San Antonio Room 241 San Jose, CA 95113-1402 (408) 277-1292
Fresno 2550 Mariposa Mall, Room 2035 Fresno, CA 93721-2219 (559) 445-5355	**Redding** 2115 Civic Center Drive, Room 15 Redding, CA 96001-2796 (530) 225-2047	**San Luis Obispo** 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159
Goleta 6755 Hollister Avenue, Room 100 Goleta, CA 93117-5551 (805) 968-4158	**Riverside** 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347	**Santa Ana** 605 W Santa Ana Blvd. Bldg 28, Room 451 Santa Ana, CA 92701 (714) 558-4597
Long Beach 300 Oceangate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240	**Sacramento** 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158	**Santa Rosa** 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452
Los Angeles 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389	**Salinas** 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058	**Stockton** 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980
Marina del Rey 4720 Lincoln Blvd, 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820	**San Bernardino** 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522	**Van Nuys** 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367

TRAVELERS

travelers.com

MCMINN COMPANIES

JAMES MCMINN INC. MCMINN EQUIPMENT RENTAL & LEASING, INC.

BENEFIT INCENTIVE PROGRAM

PLAN EFFECTIVE DATE: 8/1/17
GRADE CHECKER/OPERATOR/LABORER

EFFECTIVE AFTER 120 DAYS OF EMPLOYMENT OR 120 DAYS AFTER 8/1/17 WHICHEVER IS LATER

HOLIDAYS

THE FOLLOWING 8 HOLIDAYS WILL BE OBSERVED AND EMPLOYEES WILL **NOT** BE PAID:

NEW YEARS DAY	VETERAN'S DAY
MEMORIAL DAY	THANKSGIVING DAY
INDEPENDENCE DAY	DAY AFTER THANKSGIVING
LABOR DAY	CHRISTMAS DAY

SICK DAYS

THE COMPANY (S) WILL PAY 3 SICK DAYS PER YEAR - THREE DAYS WILL ACCRUE AFTER 90 DAYS OF EMPLOYMENT - AS PER THE CALIFORNIA STATE PAID LEAVE LAW

THESE DAYS MAY BE USED FOR SICK, DOCTORS APPOINTMENTS, VACATION, HOLIDAYS AND PERSONAL MATTERS THAT REQUIRE TIME OFF FROM WORK

UNUSED SICK DAYS CANNOT BE CARRIED OVER TO FOLLOWING YEAR, NOR WILL THEY BE PAID IN LIEU OF TIME OR AT TERMINATION - EXCEPT AS PER THE CA PAID LEAVE LAW - UNDER NO CIRCUMSTANCES WILL MORE THAN 3 DAYS BE PAID IN ANY ONE YEAR.

BENEFIT DAYS

THE COMPANY (S) WILL PAY 5 BENEFIT DAYS PER YEAR - FIVE DAYS WILL ACCRUE ON THE ANNIVERSARY OF THE FIRST YEAR OF EMPLOYMENT OR 8/1/18 WHICHEVER IS LATER AND EVERY YEAR THEREAFTER

THESE DAYS MAY BE USED FOR SICK, DOCTORS APPOINTMENTS, VACATION, HOLIDAYS AND PERSONAL MATTERS THAT REQUIRE TIME OFF FROM WORK

FOUR DAYS PER YEAR MAY BE CARRIED OVER TO THE FOLLOWING YEAR BUT IN NO CASE MORE THAN 12 DAYS TOTAL - UNUSED BENEFIT DAYS WILL NOT BE PAID IN LIEU OF TIME NOR AT TERMINATION

ALL EMPLOYEES ARE RESPONSIBLE FOR ADVISING PAYROLL IF THEY ARE USING ONE OF THEIR ALOTTED BENEFIT DAYS. ANY PLANNED TIME OFF NEEDS TO BE APPROVED BY YOUR IMMEDIATE SUPERVISOR. USE OF BENEFIT DAYS MUST BE NOTED ON DAILY FOREMAN'S REPORT. IT WILL NOT BE PAID IF NOT SO NOTED.

SUPPLEMENTAL INCENTIVE

AFTER 120 DAYS OF FULL-TIME EMPLOYMENT, AS DEFINED HEREON, THE EMPLOYEE WILL BE ELIGIBLE TO RECEIVE THE BENEFIT SUPPLEMENTAL INCENTIVE OF $550 PER MONTH (GROSS)

FULL-TIME DEFINITION

FULL-TIME EMPLOYEE WILL BE DEFINED AS WORKING A MINIMUM OF 125 HOURS PER MONTH. IF THE MINIMUM HOURS ARE NOT MET FOR ANY GIVEN MONTH THEN BENEFIT INCENTIVE WILL NOT BE PAID. HOURS WILL BE CALCULATED BASED ON PAY DATES NOT ACTUAL DAYS WORKED.

IF HOURS CANNOT BE MET DUE TO LACK OF WORK AVAILABLE TO EMPLOYEE BY JMI, THE BENEFIT INCENTIVE WILL BE SUSPENDED UNTIL THE MINIMUM OF 125 HOURS PER MONTH IS RE-ESTABLISHED. IF AN EMPLOYEE OBTAINS WORK ELSEWHERE DURING THIS PERIOD EMPLOYEE WILL BE DEEMED TERMINATED.

RESIGNATION/TERMINATION

IF EMPLOYEE RESIGNS OR IS TERMINATED BENEFIT PACKAGE IN ITS ENTIRETY WILL BE FORFEIT AT SUCH TIME. IF EMPLOYEE IS RE-HIRED AT A LATER DATE ELIGIBILITY REQUIREMENTS AS STATED ABOVE MUST BE MET. NO REINSTATEMENT OF PRIOR BENEFITS WILL BE ALLOWED UPON REHIRE.

SUBJECT TO CHANGE AT ANYTIME

ACKNOWLEDGED: _____

DATE: _____