

ECB SERVICES, INC.

New Hire Information Form

Company Name: ECB Services, Inc.

Co-Employer: _____

Address: 100 S. Pace Blvd

City: Pensacola, FL 32502

Phone No.: (850) 475-1555

NOTE TO EMPLOYEES:

Make sure you read all of the following carefully and initial all of the appropriate sections. Please Print All Information Legibly And Completely.

Status: New Hire ___ Re-Hire ___

Social Security _____ Date of Birth _____ Sex: Male ___ Female ___

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City, State, Zip _____

Home Telephone # (including area code) _____ Alternate # _____

Emergency Contact _____ Relationship _____

Emergency Telephone Numbers: Home _____ Work _____

Ever convicted of a felony? ___ No ___ Yes, Explain _____

Employee Signature _____

This area to be completed by Company Authorized Representative

Workers' Comp Code _____ Hire Date _____ Title _____ Part-time _____

Department _____ Classification _____ Full time _____

Method & Rate of Payment Hourly \$ _____ Salary \$ _____ Other _____

Normal # of Hours per Week 25 Hours or Less _____ 25 Hours or More _____

Authorized Representative _____

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 2010	
1 Type or print your first name and middle initial. _____		Last name _____		2 Your social security number _____	
Home address (number and street or rural route) _____		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. <input type="checkbox"/>			
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5		6 \$	
6 Additional amount, if any, you want withheld from each paycheck		6		7	
7 I claim exemption from withholding for 2010, 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 <input type="checkbox"/>		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 (Form is not valid unless you sign it.) <input type="checkbox"/>		Date <input type="checkbox"/>			
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) _____	

ECB SERVICES, INC.

TERMS AND CONDITIONS OF EMPLOYMENT

I, the undersigned employee, acknowledge by my signature that I have been informed that I am a leased employee of ECB Services, Inc., leased to _____ (“Client”). I understand and agree that this agreement may be assigned by ECB Services, Inc. at its sole discretion to any licensed employee leasing company as listed with Florida’s Department of Business and Professional Regulation. I further understand and agree that either my employer or I can terminate our employment relationship at any time, as I am an at will employee. I also understand and agree that if ECB Services, Inc. does not receive payment from the client for services which I perform as a leased employee, ECB Services, Inc. will pay me the current minimum wage (and/or the legally required overtime wages, if applicable) for any such pay period. I also agree that if at any time during my employment I am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, or marital status, or if I am subjected to any type of harassment, including sexual harassment, I will immediately contact ECB Service’s Human Resource Manager at (850) 475-1555 or the on-site supervisor of the leased client in order to obtain assistance in the resolution of such matters. I understand that I am on probation as an employee for the first 90 days of my employment that started on _____ for the purposes of the Florida Unemployment Compensation Law. I also agree that should I be dismissed or reassigned from the leased client’s services, I will notify ECB Services, Inc. within a 72-hour period. Failure to do so could affect unemployment benefits, if applicable.

DRUG-FREE WORKPLACE POLICY NOTICE TO APPLICANT:

It is the policy of ECB Services, Inc., that all employees are prohibited from the unlawful manufacture, distribution, dispensation, possession, or use of any controlled substances, including alcohol, in the workplace and remote job sites. Drug and alcohol testing will occur after every job related injury. All benefits will be denied if tests are positive. Testing will occur on a random basis and if there is reasonable suspicion. The following drugs will be tested for according to company policy: alcohol, cocaine, depressants, marijuana/cannabis, narcotics and stimulants. Any employee violating this policy may be subject to immediate discharge. The signature below is acknowledgment that I have read and understood ECB Service’s drug-free workplace policy. I understand as a condition of my employment I may be asked to voluntarily submit to a pre-employment drug test and I agree to follow, without reservation, the drug-free workplace policy.

WORKERS’ COMPENSATION REQUIREMENTS:

I agree to immediately report all on-the-job injuries to my supervisor. I also agree to post-accident drug and alcohol testing within 24 hours of my injury, where permitted by law. I will comply with all medical treatment authorization regulations and managed care plans as applicable under state law. If the treatment situation is an emergency I understand I can initially be treated at any emergency treatment facility or call 911. I understand that ECB Services, Inc. will have my claim assigned to an insurance adjuster who will assist me and authorize any additional treatment. I acknowledge that it may be a criminal felony to file a false workers’ compensation claim.

SAFETY REQUIREMENTS:

I agree to follow all company safety policies and to use/wear all employer-supplied personal protective equipment, such as but not limited to: safety glasses, gloves, goggles, hard hats, harnesses, tie-offs, steel-toed boots, masks, respirators, etc. I agree to operate all machinery in accordance with the manufacturer’s safety standards and will not remove any safety guards or alter the machinery. I agree to report any unsafe conditions, defective equipment or machinery I observe/use to my supervisor immediately. I acknowledge that if I refuse to wear safety equipment or obey safety rules that I may be subject to termination and possible reduction in workers’ compensation benefits as defined by law.

ASSISTANCE:

If I have any questions that my worksite employer cannot answer regarding workers’ compensation, safety policy, unsafe working conditions, equipment or machinery, I acknowledge I can contact ECB Service’s Risk Management Department for assistance.

CERTIFICATION AND AGREEMENT

I certify the answers given herein are true and complete to the best of my knowledge. I authorize investigation of statements contained herein as may be necessary. I understand that false or misleading statements may result in termination of employment. If hired, I understand my employment is probationary for a period of 90 days.

By signing this document, I acknowledge that I have read (or had read to me), and fully understand all conditions of employment and job safety rules on the reverse side of this form.

Employee Name (printed) _____

Employee Signature _____