



**KBS Staffing**  
**480 W. Alluvial Avenue**  
**Fresno, CA. 93650**  
**Phone number: 559-436-6800**

## *Employment Agreement*

**Client Company:** \_\_\_\_\_ Personnel Staffing Group, LLC. DBA KBS Staffing \_\_\_\_\_

**Client ID:** \_\_\_\_\_

**Client Company Address:** \_\_\_\_\_ 480 W. Alluvial Avenue \_\_\_\_\_

**Client Company City, State, Zip:** \_\_\_\_\_ Fresno \_\_\_\_\_ CA \_\_\_\_\_ 93650 \_\_\_\_\_

**Client Company Phone:** \_\_\_\_\_ 559-436-6800 \_\_\_\_\_

**Applicant's Name:** \_\_\_\_\_

**Start Date:** \_\_\_\_\_ **W/C Code:** \_\_\_\_\_

**Rate(s) of Pay:** \$ \_\_\_\_\_ - \_\_\_\_\_ **Rate(s) by:** \_\_\_\_\_

(ie. Hourly, Weekly, Salary)

**Overtime Rate(s) of Pay:** \_\_\_\_\_ **Regular Pay day:** \_\_\_\_\_

**Military Veteran?** \_\_\_\_\_

**Allowances:** \_\_\_\_\_

**Applicant's Social Security #:** \_\_\_\_\_

**Applicant's Address City, State, Zip:** \_\_\_\_\_

**Applicant's Phone:** \_\_\_\_\_

**In case of emergency, please notify:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

### EEO-1 Report Information

The following information pertains to applicable annual Federal EEO-1 reports. Information received will not be used in any way to evaluate the employee

**Check one Below:**

	White <small>(not Hispanic origin)</small>	Black <small>(not Hispanic origin)</small>	Hispanic	Asian or Pacific Islander	American Indian or Alaskan Native	Native Hawaiian or Other Pacific Islander	Two or More Races <small>(not Hispanic origin)</small>
<b>Male</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Female</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Marital Status:</b> <small>(Check One)</small>		Married <input type="checkbox"/>		Married (withhold at higher single rate) <input type="checkbox"/>		Single <input type="checkbox"/>	

**Employee Initials Here:** \_\_\_\_\_



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Welcome to Personnel Staffing Group, LLC. DBA KBS Staffing (here in after "KBS").The company for which you perform services uses KBS to issue your paychecks, process your year-end W-2s, and to offer a variety of employee benefits for your consideration. Under This agreement, you will be considered an employee of KBS. All information contained in this employment agreement is important to your employment with KBS. All blanks must be completed and you must sign the agreement, including the I-9 and W-4. A copy of your Social Security card is requested for employment tax purposes.

<b>Check One of The Following:</b>					
Official or Manager	<input type="checkbox"/>	Technician	<input type="checkbox"/>	Craft Worker	<input type="checkbox"/>
Professional	<input type="checkbox"/>	Office (clerical)	<input type="checkbox"/>	Laborer	<input type="checkbox"/>
Sales Worker	<input type="checkbox"/>	Operatives	<input type="checkbox"/>	Service Worker	<input type="checkbox"/>

**At-Will Employment.**

Employee's employment and compensation can be terminated at any time, with or without cause or notice, at the option of Employee or KBS. No agreements contrary to this at-will arrangement are valid unless they are in writing and signed by the President of KBS. No supervisor or representative of Client Company or KBS have the authority to make implied or express agreements contrary to the foregoing. Termination of this Agreement may not necessarily terminate employment with Client Company.

**Client Company Paid Leave Policies and Other Benefits.**

In the case that Client Company maintains policies providing paid leave benefits such as vacation, sick leave, PTO, or severance pay, Client Company is solely responsible for paying any accrued benefits under such policies during employment and at the time of termination. KBS does not provide, and has no policy providing, vacation or other paid leave benefits. To the extent paid leave benefits are paid through KBS's payroll to Employee, it is solely as a payroll service on behalf of Client Company. Similarly, to the extent Client Company provides other benefits pursuant to policies to which KBS is not a party, such as stock options, bonuses, profit sharing, retirement benefits, and so forth, Client Company is solely responsible for providing the benefits prescribed by those policies.

**Assignment**

If Client Company files any form of bankruptcy, Employee will and hereby transfers to KBS all of his/her rights as a employee for the purposes of payment of wages and applicable payroll taxes. For this right, KBS will compensate Employee an additional five percent (5%) premium, on those amounts KBS receives from client as a result of the assignment of Employee's rights.

**Policies and Benefits.**

Employee agrees to abide by the policies of KBS, including but not limited to policies contained in any applicable Employee Handbook. Employee understands that eligibility and coverage for KBS benefits is controlled by the terms and conditions of the applicable Plan Documents.

**Reporting Discrimination and Harassment.**

KBS does not tolerate unlawful harassment or discrimination against any employee. If at any time Employee is subjected to or witnesses unlawful harassment or discrimination, including but not limited to harassment or discrimination based on race, sex, sexual orientation, pregnancy, age, religion, citizenship, color, veteran status, military status, unfavorable discharge from military service, prohibited retaliation, national origin, ancestry, mental or physical handicap, disability, or marital status, Employee will immediately contact KBS's Human Resources department by phone (559)-436-6800 in order to obtain assistance.

**Arbitration**

KBS promotes a voluntary system of alternative dispute resolution that utilizes binding arbitration to resolve all disputes that may arise out of the employment context.

**Employee Initials Here:** \_\_\_\_\_

### **Medical Authorization**

I hereby authorize the release of any and all medical, hospital, vocational and psychological records and other information related to my injury, illness or worker's compensation claim (hereinafter collectively referred to as "Medical Information") to KBS Staffing, its employees, agents and authorized representatives. I hereby permit KBS to review and obtain copies of any and all Medical Information and to discuss pertinent Medical Information with professionals involved in my health care treatment. I hereby give KBS permission to release the Medical Information to healthcare providers, third party administrators, federal or state court, Workers' Compensation Boards, employers, insurers and any other party who may be involved with my claim, treatment or vocational rehabilitation, or as required by law. Further, pursuant to Title 42 Section 1395y, carriers are required to share claimants' Medical Information to enable the Centers for Medicare & Medicaid Services, formerly known as Healthcare Financing Administration (CMS) to determine eligibility for benefits. I hereby give KBS Staffing Workforce permission to discuss, disclose and release any Medical Information with or to CMS in connection with my claim. I hereby release KBS Staffing from any liability or loss due to the release of any Medical Information. I understand that all information released will be handled confidentially and in accordance with all applicable laws. I also understand that this authorization shall stay in effect until the closure of the claim file. I certify that this authorization has been made voluntarily and that the information given herein is accurate to the best of my knowledge. A photocopy of this authorization shall have the same validity as the original.

### **Accident/Injury Guidelines & Procedures**

1. All injuries must first be reported to your immediate supervisor, who will, then report the incident to KBS Workers' Compensation Department before authorization will be given for medical treatment. Exception: emergency situations or if the injury occurs after hours and/or on the weekends.
2. A drug screen is required within 24 hours for all injuries. In accordance with state law, a positive result relieves KBS and its insurers from any responsibility for any medical expenses incurred in connection with your injury. Refusal to submit to a drug test will result in the same consequences as a positive drug test result. If an employee tests positive on a post-accident drug test, they will be discharged for violation of the company substance abuse policy, and workers' compensation benefits and/or medical bills incurred by the employee will be denied.
3. The employee is required to inform the doctor or medical facility that light duty work is available. The employee will be required to work light duty per the doctor's instructions.
4. Employees are required to forward all medical information associated with the work-place injury/illness (doctor's work status report, medical records, etc.) within 24 hours of receipt.
5. Employees are required to complete an Employee Accident/Injury Report within 24 hours of the injury/illness.

### **MPN (Medical Provider Network) Confirmation**

I have received the MPN (Medical Provider Network) I acknowledge that my employer has posted the provider listings for the MPN. I acknowledge that if I do not complete the enrollment forms and return it to my employer within 30 days, my employer will enroll me in the MPN. I acknowledge that this letter pertains to workers' compensation only. This is not a health plan. This applies only to work related injuries or work related illnesses.

### **Substance Abuse Policy**

Any employee on duty or on company property who possesses, sells, receives, or is determined to have measurable levels of any illegal drug, or sufficient alcohol to impair performance in their blood or urine, will be subject to immediate discharge, and in appropriate situations, referred to law enforcement authorities. See your Employee Handbook regarding procedures applicable to prescriptive medications. Periodically, unannounced inspections will be made of persons entering or leaving company work-sites by authorized company representatives. Entry onto company property is deemed to be consent to an inspection of a person, locker, vehicle, or any other personal effects. KBS also reserves the right to require employee testing for illegal or controlled drugs or alcohol, based on reasonable suspicion and in the other circumstances described in the Employee Handbook.

### **Deductions**

By initialing this page below and signing this employment agreement form I authorize deductions when applicable to be made out of my paycheck for tools, uniforms, health insurance, errors in payroll, garnishments, overpayments, bank fees for stop payment of a lost or damaged check, and any other work-related deductions. I agree that if I should leave or be discharged from employment at (the above client company of KBS) before the full amount is paid, any earnings over minimum wage will be applied to my deduction loan. The amount deducted from my last paycheck may be greater than the amount shown for each paycheck in accordance with the applicable labor law.

**Employee Initials Here:** \_\_\_\_\_



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Please check one of the item boxes next to the option in which you would like to designate below:

Form with checkboxes and text options for MPN enrollment. Includes fields for Doctor's Name, Phone Number, Address, City, State, and Zip Code. Includes a note: (Write name and address of your personal physician, personal chiropractor or personal acupuncturist.)

WORKERS' COMPENSATION INFORMATION:

Insurance Carrier: Zurich American Insurance Co.
Address: 1400 American LN. Schaumburg IL 60196
Telephone Number: 847-605-6000
Policy Number: WC466477403

This Employment Agreement form is in compliance with labor code LC2810.5

BY SIGNING BELOW I ACKNOWLEDGE THE RECEIPT OF MY EMPLOYER INFORMATION, MY WAGE INFORMATION, A COPY OF THIS EMPLOYMENT AGREEMENT AND MY EMPLOYER'S WORKERS COMPENSATION INFORMATION. BY SIGNING BELOW I ALSO ACCEPT THE TERMS OF THIS EMPLOYMENT AGREEMENT FORM AND CONFIRM THAT ALL MY PERSONAL AND EMPLOYMENT INFORMATION IS ACCURATE AND CORRECT:

(PRINT NAME of Employer representative)

(PRINT NAME of Employee)

(SIGNATURE of Employer representative)

(SIGNATURE of Employee)

(Date provided to employee & signed by representative)

(Date received by employee & signed by employee)