NOTICE TO EMPLOYEE

Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: _____

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):

_____

Physical Address of Hiring Employer's Main Office:

_____

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

_____

Hiring Employer's Telephone Number: _____

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: _____

Physical Address of Main Office: _____

Mailing Address: _____

Telephone Number: _____

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: _____
Address: _____
Telephone Number: _____
Policy No.: _____
□ 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

_____	_____
(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.

PAYCHEX

Direct Deposit Enrollment/Change Form

Company Name_____ **Client Number**_____

Employee/Worker Name_____ **Employee/Worker Number**_____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer.

EMPLOYERS: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS – *PLEASE PRINT IN BLACK/BLUE INK ONLY*

Type of Account	Routing/Transit Number	Checking/Savings Account Number*	Financial Institution ("Bank") Name	I wish to deposit (check one):
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $_____ .00 ☐ Remainder of Net Pay
☐ Checking ☐ Savings				☐ _____ % of Net ☐ Specific Dollar Amount $_____ .00 ☐ Remainder of Net Pay

One of the following is required to process this enrollment (check one):

☐ Voided check with name imprinted (no starter checks)

☐ Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)

☐ Bank letter or specification sheet (the signature of your local bank representative MUST be included)

☐ Other Bank Documentation from your Financial Institution – If this box is checked the employer must sign this confirmation:
I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc.

Employer Signature:_____ **Date** _____

***Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT IN BLACK/BLUE INK ONLY*

Routing/Transit Number	Checking/Savings Account Number*	Financial Institution ("Bank") Name	Change My Deposit Amount to:
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay
			☐ From _____% to____% of Net ☐ From $ _____.00 To $_____.00 ☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer to deposit my wages/salary into the bank accounts specified above. I agree that direct deposit transactions I authorize comply with all applicable law. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

DATE:

Personnel Emergency Record

Name:		**Social Security #:**	
Address:		**Home Phone:** **Cell Phone:**	

In case of emergency notify:

Name:		**Relationship:**	
Address:		**Home Phone:**	
		Cell Phone:	
Name:		**Relationship:**	
Address:		**Home Phone:**	
		Cell Phone:	

CONFIRMATION OF RECEIPT

I have received my copy of the JT2 Integrated Resources' (JT2) employee handbook. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures contained in the handbook.

I understand and agree that nothing in the employee handbook creates or is intended to create a promise or representation of continued employment and that employment at JT2 is employment at-will; employment may be terminated at the will of either the Company or myself. My signature certifies that I understand that the foregoing agreement on at-will status is the sole and entire agreement between JT2 and myself concerning the duration of my employment and the circumstances under which my employment may be terminated. It supersedes all prior agreements, understandings, and representations concerning my employment with JT2.

I understand that except for employment at-will status, any and all policies or practices can be changed at any time by the Company. JT2 reserves the right to change my hours, wages, and working conditions at any time. I understand and agree that other than the President of JT2, no manager, supervisor, or representative of the Company has authority to enter into any agreement, express or implied, for employment for any specific period of time, or to make any agreement for employment other than at-will; only the President of JT2 has the authority to make any such agreement and then only in writing, signed by the President of JT2.

Employee Name (printed): _____

Employee Signature: _____

Date: _____

HARASSMENT FREE WORKPLACE CONFIRMATION OF RECEIPT

I have received the Harassment-Free Workplace section contained in the JT2 Integrated Resources Employee Handbook.

I have read, understand, and agree to follow the policy. I understand that any employee that engages in conduct prohibited by the policy will be subject to disciplinary action, up to and including termination.

I understand it is my obligation to refrain from engaging in conduct in violation of the policy and also to report conduct that I believe is harassing or discriminatory to enable the Company to take the appropriate action.

Employee Name (printed): _____

Employee Signature: _____

Date: _____

EMPLOYEE ACKNOWLEDGEMENT FORM

CODE OF SAFE WORK PRACTICES

I _____ (PRINT) , hereby acknowledge that I have received, read, and understand the “Code of Safe Work Practices” for JT2 Integrated Resources.

I agree to conform to all practices, safety rules, and regulations relating to safe work performance.

I understand that my failure to follow these safety procedures will result in disciplinary action up to and including discharge.

I further understand that:

a) It is my responsibility to report all unsafe conditions or violations of the Code of Safe Work Practices to my supervisor or other management personnel in order to minimize the potential of injury to my fellow workers.

b) I am encouraged to inform my immediate supervisor of any hazards on the job without fear or reprisal, and that should my assistance create any such action or related intimidation, that I am encouraged to contact the IIPP Administrator or management by phone or mail.

_____ Date _____
(Signature of Employee)

_____ Date _____
(Signature of Manager)