



## Employee Acknowledgement

I acknowledge by my signature below that I have been informed that I will be a co-employee of StaffScapes (PEO), a Professional Employer Organization, assigned to perform services to: \_\_\_\_\_ (Client Name). I understand and agree that, if hired, my employment is for no definite period and is considered a relationship "at-will" and does not constitute a permanent contract of employment. Either PEO, Client, or employee can terminate the employment relationship at any time. I further understand and agree that if the PEO does not receive payment for services performed by me as a co-employee, from the Client to whom I am assigned, the PEO will pay me the applicable minimum wage for the actual hours worked (or the legally required minimum salary or overtime pay). Any and all other wages (including but not limited to accrued sick or vacation pay, severance agreement, and PTO) are the sole responsibility of the Client.

I have been informed and agree that if my employment with Client ends for any reason, I must report to PEO at 303-466-7864 or 800-551-7607 within seventy-two (72) hours for possible re-assignment, and my failure to do so will be considered as a voluntary resignation of my employment with the PEO, regardless of the reason for termination.

I certify that all the information on this application, my resume, or any supporting documents are correct, and I understand that any misrepresentation, falsification, or omission of any information will be grounds for disciplinary action, up to and including termination of my employment. I authorize the investigation of all statements contained in this application and hereby authorize PEO to request and receive appropriate report(s) which may include information regarding my character, general reputation, personal characteristics, and job verification. I authorize any former employer, medical provider, or institution to release information and documentation of my former employment, education, medical, or other history which PEO or PEO's Workers' Compensation carrier deems relevant to my employment. I hereby release all such providers and recipients of information from any liability in connection with the above.

In addition, I also agree that if any time during this application for employment process, as well as during my employment, I am involved in any employment dispute, or am subjected to any type of discrimination, including discrimination because of race, sex, age, religion, color, national origin, disability, genetics, sexual orientation, disability, marital or veteran status, or if I am subjected to any type of harassment including sexual harassment, I will immediately contact PEO's Human Resources Department at 303-466-7864 or 800-551-7607 to obtain assistance in the resolution of such matters.

### DRUG-FREE WORKPLACE POLICY NOTICE:

It is the policy of PEO that all employees are prohibited from the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance (including alcohol) in the workplace, and remote job sites. Drug and alcohol testing may occur after every job-related accident; benefits will be denied or reduced based on a positive test result. Testing shall also occur if there is reasonable suspicion. Any employee violating this policy will be subject to immediate discharge. Clients and employees who do not understand this policy should contact PEO's Human Resource Department for clarification.

The following six drugs will be tested for under our company policy:

1. Alcohol
2. Cocaine
3. Depressants, e.g. barbiturates
4. Marijuana/Cannabis
5. Narcotics, e.g. heroin
6. Stimulants, e.g. amphetamines

I acknowledge that I have thoroughly read and understand the drug-free workplace policy. I understand that as a condition of my employment I must voluntarily submit to pre-employment drug testing and agree to follow, without reservation, the drug-free workplace policy.

Further, I certify that I have been fully advised that if I am injured on the job, regardless of how minor the injury may seem, I am to report the injury immediately to my supervisor or PEO's Workers' Compensation Department. I understand that any false or misleading answers to these questions can be sufficient reason for denial of benefits under the prevailing state Workers Compensation Act, and basis for termination of employment. I also understand that my answers will be researched to verified by investigation.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_