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SOUTH EAST PERSONNEL LEASING, INC. (SPLI) CO-EMPLOYMENT APPLICATION

(SOLICITUD PARA CONTRATO DE CO-EMPLEADOS ARRENDADOS)

Payroll Fax: **(727) 437-0000**

*_____ _____

Client Company Name (Compañia del Cliente) **Location** (Ubicación) **(if multiple client locations/offices exist)**

SECTION 1 – TO BE COMPLETED BY THE APPLICANT (SECCIÓN 1 – PARA SER COMPLETADO POR EL SOLICITANTE)

*_____ *_____ _____ *_____

Last Name (Apellido) **First Name** (Primer Nombre) **MI** (Initial del segundo) **SSN** (Numero de Seguro Social)

*_____ _____ *_____ *_____ *_____

Applicant Address (Dirección del Solicitante) **Apt/Lot/etc** (Apt. o lote) **City** (Ciudad) **State** (Estado) **Zip Code** (Codigo postal)

_____ *_____ _____

Phone Number (Numero de Teléfono) **Birthdate** (Fecha de Nacimiento) **Email Address** (Correo Electrónico)

EEO Data: We are subject to certain government recordkeeping and reporting requirements for the administration of civil rights laws and regulations. To comply with these laws, we invite you to voluntarily self-identify your race or ethnicity and gender. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual. (Nosotros estamos sujetos a ciertos requerimientos de compilación de datos y reportes para la administración de leyes y regulaciones de los derechos civiles. Para cumplir con estas leyes, te invitamos a voluntariamente identificar tu raza y género. Proveer está información es voluntario y negarse a suministrarla no traerá ninguna consecuencia adversa. La información obtenida se mantendrá confidencial y solamente se utilizara de acuerdo con las leyes aplicables, ordenanzas y regulaciones ejecutivas incluyendo aquellas que requieren el resumen y reporte de la información al gobierno federal para el cumplimiento de derechos civiles. Cuando se reporten, estos datos no identificaran a ningún individuo en específico.)

Gender: ☐ **M** ☐ **F** **Ethnicity:** ☐ **White/ Caucasian** ☐ **Black/African American** ☐ **Hispanic/ Latino** ☐ **Asian** ☐ **American Indian/ Alaskan Native** ☐ **Hawaiian/ Pacific Islander** ☐ **Two or More Races**

I understand and agree to the following: I am not yet covered by the services provided to the co-employees of South East Personnel Leasing, Inc. (SPLI). As such, if I suffer an injury or have suffered an injury related to work while working for the Client and before I am accepted as a co-employee by SPLI, the Client will be responsible for that injury. Payroll will not be processed and workers' compensation coverage will not be provided until and unless all pages of the SPLI Employee Leasing Application are completed and signed by the applicant, the complete SPLI Employee Leasing Application is delivered to SPLI and SPLI accepts the applicant as a co-employee. The SPLI Co-Employment Application includes all of the following documents: This page, the Applicant Agreement, Use of Personal Protective Equipment Form, Acknowledgement of Alcohol and Drug Policy, Employee Acknowledgement of the Medical Provider Network, Arbitration Agreement, Predesignation of Personal Physician Form , Form I-9, Form W-4, and Form DE 4.The complete Form I-9, Form W-4, and Form DE 4, including instructions, can be obtained at https://spli.com/docs.php. . (Yo entiendo y estoy de acuerdo con lo siguiente: Aún no soy un empleado contratado de South East Personnel Leasing, Inc. (SPLI). En consecuencia, si yo sufriera una lesión o hubiera sufrido una lesión relacionada con el trabajo mientras trabajaba para la Compañía Cliente y antes de ser aceptado como un empleado contratado por SPLI, la Compañía Cliente será responsable de esa lesión. No se procesará la Planilla de Pago y no se proporcionará cobertura de Compensación Obrera hasta y a menos que todas las páginas de la aplicación de SPLI para contrato de empleados, hayan sido llenadas y firmadas por el Solicitante, se haya sido entregada a SPLI y SPLI haya aceptado al Solicitante como un empleado contratado. La Solicitud de SPLI de Contratación de Empleados incluye la totalidad de los siguientes documentos: Esta página, el Reconocimiento del Solicitante, Reconocimiento de Póliza de Alcohol y Droga, Reconocimiento del Empleado Acerca del Proveedor de Servicios Medicos, Acuerdo de Arbitraje, Designación Previa de Médico Personal, Formulario I-9, Formulario W-4, y Formulario DE 4. La versión completa del Formulario I-9, Formulario W-4, y Formulario DE 4 incluyendo las instrucciones, se pueden obtener en https://spli.com/docs.php.)

*_____ *_____

Applicant Signature (Firma del Solicitante) **Date (Fecha)**

SECTION 2 – TO BE COMPLETED BY THE CLIENT COMPANY (SECCIÓN 2 – PARA SER COMPLETADO POR EL CLIENTE)

*_____ * _____

Original Client Hire Date (Fecha original de empleo el Cliente) **Job Description** (Descripción del Trabajo)

*_____ _____ _____ _____

Work State (Estado de Trabajo) **W/C Code** (Codigo de Trabajo) **Home Department** (Departamento) **Employee ID** (ID de Empleado)

* **Pay Rate and Method -** Must comply with FLSA guidelines (Tasa y método de pago - debe cumplir con FLSA directrices)

☐ Hourly (por Hora) $ _____

☐ Salary (Salario) $ _____ ☐ Check if salary employee qualifies for OT exemption (empleado califica para la excepción de horas extras)

☐ Commission/Piecework (Comisión/Pagos por pieza)

* **Pay Cycle** (Ciclo de Paga)

☐ Weekly (Semanal)

☐ Bi-Weekly (Quincenal)

☐ Other (Otros): _____

* **Employment Type** (Tipo de Empleo)

☐ Full-Time (> 30 hours avg. per week) - empleado a tiempo completo (promedio > 30 hrs por semana)

☐ Part-Time (< 30 hours avg. per week) - empleado a tiempo parcial (promedio < 30 hrs por semana)

☐ Variable (cannot determine if the EE will avg. at least 30 hours per week) - horas variables (no se puede determinar si el empleado va promediar al menos 30 hrs por semana)

☐ Seasonal (< 6 consecutive months worked during calendar year) - empleado de temporada (trabajando 6 meses consecutivos durante el año calendario)

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your pay.

Personal Information	
First, Middle, Last Name	Social Security Number
Address City State ZIP Code	Filing Status ☐ Single or Married (with two or more incomes) ☐ Married (one income) ☐ Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (**Worksheet A**) _____
   - 1b. Number of allowances from the Estimated Deductions (**Worksheet B**) _____
   - 1c. Total Number of Allowances you are claiming _____
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)** _____

OR

Exemption from Withholding

3. I claim exemption from withholding for 2026, and I certify I meet both conditions for exemption. (Check box here) ☐

OR

4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here) ☐

Under penalty of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number
SOUTH EAST EMPLOYEE LEASING SERVICES, INC **2739 U.S. HWY 19 NORTH HOLIDAY, FL 34691**	**312 4974 1**

The *Employee's Withholding Allowance Certificate* (DE 4) is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

As of January 1, 2020, the *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) is used for federal income tax withholding **only**. You must file the state form DE 4 to determine the appropriate California PIT withholding.

If you do not provide your employer a completed DE 4, your employer must use Single with Zero withholding allowance.

Check Your Withholding: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

Exemption From Withholding: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal and state income tax last year, and
2. You do not expect to owe any federal and state income tax this year.

If you continue to qualify for the exempt filing status, a new DE 4 designating **exempt** must be submitted by February 15 each year to continue your exemption. If you are not having federal and state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax withholding on your wages if

(i) Your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) You are present in California solely to be with your spouse; and

(iii) You maintain your domicile in another state.

If you claim exemption under this act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

Download Instructions

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.) _____
- ☐ 4. An alien authorized to work until _____ (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

When completing electronically, the employee must first select a Citizenship/Immigration Status in Section 1 above before you can complete this section

Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

I. APPLICANT AGREEMENT

I, the undersigned applicant, acknowledge by my signature that I have been informed that if accepted, I will be a co-employee of South East Personnel Leasing, Inc. ("SPLI") and _____ (Client Company). A co-employee is an employee with two employers: the worksite employer (Client) and a Professional Employer Organization (SPLI). The co-employee relationship allows SPLI to provide certain benefits and services to Client and its employees. Employee agrees and acknowledges that SPLI has limited responsibilities as a co-employer and does not assume all of the employer responsibilities of Client. I further understand that if accepted, either SPLI or I can terminate our relationship at any time, as I will be an at-will co-employee of SPLI. No agreements contrary to this at-will arrangement are valid unless they are in writing and signed by the President of SPLI. No supervisor or representative of Client or SPLI have the authority to make implied or express agreements contrary to the foregoing. Termination of my co-employment relationship with SPLI may not necessarily terminate employment with Client. I also understand and agree that if accepted, while I am a co-employee of SPLI, if SPLI does not receive payment from the Client for services which I perform as a co-employee, SPLI may, in its sole discretion and to the extent permitted by law, pay me the applicable minimum wage (or the legally required overtime pay, at the applicable minimum wage rate, in a workweek in which I have worked overtime) for any such pay period and I agree to this method of compensation. I understand and agree that SPLI has no obligation to pay me any other compensation or benefit unless SPLI has specifically, in a written agreement with me, adopted Client's obligation to me for such compensation or benefit. I understand that Client at all times remains obligated to pay me my regular hourly rate of pay if I am a non-exempt employee and to pay me my full salary if I am an exempt employee even if SPLI is not paid by the Client. I also understand and agree that during any period in which I am paid by anyone other than SPLI for performing services, including by Client, I will be considered an employee of that person or company for all purposes, including but not limited to responsibility for workers' compensation insurance and work related injuries, while providing services. SPLI shall not be responsible for work related injuries occurring while you are performing services in exchange for payments made through a person or entity other than SPLI. I also agree to comply with any drug testing policy, which SPLI may adopt, and I specifically agree to post accident drug testing to the full extent permitted by law. SPLI is in agreement with the Federal Government that marijuana is a controlled substance and will not recognize medical marijuana as a legitimate prescription. A positive test result for marijuana will be treated the same as any other positive test result, even if an employee has a medical marijuana prescription. I acknowledge that I am required to promptly report all incidents of discrimination, harassment, or retaliation, regardless of the offender's identity or position, to SPLI, 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. I understand and agree that if I am accepted as a co-employee of SPLI, I will be expressly prohibited from ever performing any work outside the State of California. If I work outside the State of California, I understand that, I will not be a co-employee of SPLI and will not be provided workers' compensation benefits through SPLI or SPLI's workers' compensation carrier should an injury related to work occur. In the event the Client maintains policies providing paid leave benefits such as vacation, sick leave, holiday pay, PTO, or severance pay, Client is solely responsible for paying any accrued benefits under such policies during my employment and at the time of termination. SPLI does not provide, and has no policy to provide vacation or other paid leave benefits. To the extent Client provides other benefits pursuant to policies to which SPLI is not a party, including but not limited to stock grants or options, bonuses, commissions, profit sharing or retirement benefits, Client is solely responsible for providing the benefits prescribed by those policies. I agree to abide by the policies of SPLI, including but not limited to policies contained in any applicable SPLI Handbook. I understand that eligibility and coverage for SPLI benefits is controlled by the terms and conditions of the applicable Plan Documents. I agree to follow all Client Company, South East Personnel Leasing, Governmental, and OSHA safety procedures. I agree to report any work-related accident, or injury, to my supervisor with the Client Company as soon as it occurs, without exception. I agree to inform South East Personnel Leasing of any safety violations I encounter in the workplace. I understand that failure on my part, to follow the above procedures, could result in disciplinary action, not to exclude termination. I understand that my sole remedy for work related injuries is the remedy provided by SPLI's workers' compensation insurance coverage.

I. RECONOCIMIENTO DEL SOLICITANTE

Yo, el solicitante infrascrito, reconozco atravez de mi firma que se me ha informado que si me aceptan como co-empleado de South East Personnel Leasing, Inc. ("SPLI") y _____ (Compañía del Cliente). Un co-empleado es un empleado que tiene dos patrones: el patron donde trabaja (Cliente) y una Organización Profesional de Patrones (SPLI). La relación de co-empleado le permite a SPLI proveer ciertos beneficios y servicios al Cliente y sus empleados. El empleado conviene y reconoce que como un co-empleador, SPLI tiene responsabilidades limitadas y no asume todas las responsabilidades de empleador del cliente. Al igual entiendo que si aceptado, ya sea SPLI o Yo podemos terminar nuestra relación en cualquier momento, pues yo seré un co-empleado de SPLI por mi voluntad. Ningunos acuerdos contrarios a este arreglo voluntario son válidos a menos que estos estén por escrito y firmados por el Presidente de SPLI. Ningún supervisor o representante del Cliente o de SPLI tienen la autoridad para hacer implicar o expresar acuerdos contrarios al presente. Terminación a mi relación de co-empleo con SPLI no necesariamente termina mi empleo con el Cliente. Yo también entiendo y convengo que si aceptado, mientras sea un co-empleado de SPLI, si SPLI no recibe pago por parte del Cliente por los servicios que yo preste como un co-empleado, SPLI puede, en su única discreción y al grado permitió por la ley, me pagara el salario mínimo aplicable (o el pago por tiempo extra exigido por la ley, a la tasa de salario aplicable en una semana de trabajo durante la cual yo haya laborado tiempo extra) por cualquier periodo de pago y yo estoy de acuerdo con este método de Compensación. Yo entiendo y convengo que SPLI no tiene obligación a pagarme por ninguna otra compensación o beneficios a menos que SPLI haya especificado, por escrito un acuerdo conmigo, adopte las obligaciones del Cliente para mí por dicha compensación o beneficio. Entiendo que el Cliente en todo tiempo se mantiene obligado a pagarme mi taza de hora regular si soy un empleado no-exento y de pagarme mi salario completo si yo soy un empleado exento aun si SPLI no recibe pago del Cliente. Yo también entiendo y convengo que durante el periodo en el cual soy pagado por cualquier identidad aparte de SPLI por servicios rendidos, incluyendo al Cliente, seré considerado un empleado de esa persona o compañía para todos los propósitos, incluyendo pero no limitado a responsabilidad de seguro de Compensación de Obreros y lesiones relacionadas al trabajo, mientras proveyendo servicios. SPLI no será responsable por lesiones relacionadas al trabaja que ocurrieron durante que usted este rindiendo servicios por cambio de pagos hechos atravez de una persona o entidad otra a SPLI. Yo también estoy de acuerdo en cumplir con cualquier póliza de pruebas de drogas, la cual SPLI pueda adoptar, y Yo específicamente estoy de acuerdo en la prueba de drogas después de cada accidente en el trabajo en toda su extensión permitida por la ley. SPLI está de acuerdo con el gobierno federal que la marijuana es una substancia controlada y no reconocerá la marijuana médica como prescripción legítima. Un resultado de prueba positivo para la marijuana será tratada igual que cualquier otro resultado de prueba positivo, aunque el empleado tenga una prescripción médica para la marijuana. Yo reconozco que es requerido que reporte prontamente a SPLI todos incidentes de discriminación, acoso, o represalia, no importa la identificación o posición del ofensor, incluyendo pero no limitado a acoso o discriminación basada en raza, sexo, orientación sexual, embarazo, edad, religión, ciudadanía, color, estado veterano, estado militar, debajo desfavorable del servicio militar, represalia prohibidas, origen nacional, ascendencia, discapacidad física o mental, deshabilitad, o estado civil. Yo entiendo y convengo que si soy aceptado como un co-empleado de SPLI, se me prohíbe expresamente realizar trabajo como un empleado de SPLI fuera del Estado de California. Si Yo trabajo fuera del Estado de California Yo entiendo, que Yo no seré un co-empleado de SPLI y que no se me proveerá beneficios de Compensación de Obreros por medio de SPLI o por la póliza de Compensación de obreros de SPLI en caso de que suceda una lesión relacionada al trabajo. En el caso que el Cliente mantenga pólizas proveyendo beneficios de permiso retribuido como vacaciones, pagos por enfermedad, pagos por día feriados, pagos por asuntos personales, o pagos por separación, el Cliente es el único responsable de pagar cada beneficio acumulado bajo dichas pólizas durante mi empleo y en el momento de terminación. SPLI no provee, y no tiene póliza para proveer vacaciones u otro tipo de beneficios pagos. Al grado que el Cliente provea otros beneficios conforme a las pólizas a las cuales SPLI no es un partido, incluyendo pero no limitado a acciones o opciones, bonos, comisiones, beneficios de plan de reparto o de retiro, el Cliente es el único responsable de proveer el beneficio dictado por esas pólizas. Yo convengo cumplir con las pólizas de SPLI, incluyendo y no limitado a pólizas contenidas en cualquier Manual aplicable a SPLI. Yo convengo que elegibilidad y cobertura por los beneficios de SPLI es controlado por los términos y condiciones de los Documentos Planeados aplicables. Yo convengo a seguir todos los procedimientos de seguridad de la Compaña del Cliente, South East Personnel Leasing, Gubernamentales, OSHA. Yo convengo en reportar cualquier accidente o lesión relacionada al trabajo, a mi supervisor de la Compaña del Cliente tan pronto y ocurra, sin ninguna excepción. Yo convengo informar a South East Personnel Leasing de cualquier violación de seguridad que Yo encuentre en el sitio de trabajo. Yo entiendo que mi falta, a seguir los procedimientos previamente indicados, puede resultar en una acción disciplinaria, la cual no excluye mi despido. Yo entiendo que mi único remedio a una lesión relacionada al trabajo es el remedio proveÃ-do por la cobertura del seguro de Compensación de Obreros de SPLI.

II. USE OF PERSONAL PROTECTIVE EQUIPMENT

I, the undersigned, understand and agree that as a condition of acceptance as a co-employee by SPLI, I am required to wear/use the personal protective equipment supplied and/or required by the Client. I agree to inform my supervisor with the Client Company immediately upon the failure of any of the equipment so the same can be promptly repaired or replaced. I will inform South East Personnel Leasing of any safety violations that I encounter. I understand that Client Company shall be solely responsible for compliance with all Cal/OSHA requirements and standards including, but not limited to, maintenance of the Injury and Illness Prevention Program, non-IIPP training, and provision and/or instruction as to use of personal protective equipment. I understand that Client Company shall keep training current and provide SPLI with adequate confirmation of training being completed before I am allowed to work. I understand and acknowledge that I must contact Client Company and SPLI if training is not provided before I begin work or if I feel that the work is unsafe.

II. USO DE EQUIPO DE PROTECCION PERSONAL

Yo el infrascrito, entiendo y convengo que como una condición de aceptación como un co-empleado de SPLI, me requieren usar/utilizar los equipo del protección personal proveídos y o requerido por el Cliente. Yo convengo de informarle inmediatamente a mi supervisor de la Compañía del Cliente sobre la falla de los equipo del protección personal proveídos para que estos puedan ser reparados o reemplazados prontamente. Yo le informare a South East Personnel Leasing de cualquier violación a la seguridad que yo encuentre. Yo comprendo que, la compañía cliente deberá ser completamente responsable por el cumplimiento de todos los requerimientos y regulaciones de CAL/OSHA los cuales incluyen, pero no se limitan al mantenimiento del programa de prevención de lesiones y enfermedades, entrenamiento no-IIPP, y el suministro de equipo de protección personal así como instrucciones para su uso. Yo comprendo que la compañía cliente deberá mantener entrenamiento actualizado y deberá proveer SPLI confirmación de que entrenamiento ha sido finalizado antes de que yo esté autorizado a trabajar. Yo comprendo y reconozco que tengo el deber de contactar a la compañía cliente y a SPLI si entrenamiento no ha sido provisto antes de comenzar a trabajar o sospecho que el trabajo es peligroso.

III. ACKNOWLEDGMENT OF ALCOHOL AND DRUG POLICY

I have read, or had read to me, a copy of this policy and I understand the consequences of violating the policy, including my obligations under the testing policy. If I did not understand the policy, I have asked for and have received an explanation. I specifically understand that my eligibility for benefits may be forfeited or reduced if I am injured on the job and either refuse to be tested or test positive for drugs or alcohol. All co-employees are prohibited from manufacturing, cultivating, distributing, dispensing, possessing or using illegal drugs or other unauthorized or mind-altering or intoxicating substances while on Client property (including parking areas and grounds), or while otherwise performing their work duties away from Client property. Included within this prohibition are lawful controlled substances, which have been illegally or improperly obtained. This policy does not prohibit the possession and proper use of lawfully prescribed drugs taken in accordance with the prescription. SPLI is in agreement with the Federal Government that marijuana is a controlled substance and will not recognize medical marijuana as a

legitimate prescription. A positive test result for marijuana will be treated the same as any other positive test result, even if an employee has a medical marijuana prescription. Co-employees are also prohibited from having any such illegal or unauthorized controlled substances in their system while at work, and from having excessive amounts of otherwise lawful controlled substance in their systems, as determined to be over the legal limit by the MRO. All co-employees are prohibited from distributing, dispensing, possessing or using alcohol while at work or on duty. Furthermore, off-duty alcohol use, while generally not prohibited by this policy, must not interfere with a co-employee's ability to perform the essential functions of his/her job. Co-employees may be required to submit to drug/alcohol screening whenever the there is a reasonable suspicion that they have violated any of the rules set forth in this policy. Reasonable suspicion may arise from, among other factors, supervisory observation, co-worker reports or complaints, performance decline, attendance or behavioral changes, results of drug searches or other detection methods, or involvement in a work related injury or accident. Additionally, co-employees in safety sensitive positions may be tested on a random or periodic basis. In addition, various job classifications are categorically subject to random or periodic drug testing to the extent permitted by applicable state and federal laws. I further consent to the results of any such drug or alcohol tests being released to the Client or SPLI's authorized representative by the Medical Review Officer (MRO). I understand that I will receive a copy of this consent form if requested. I also understand that the Post-Accident/Reasonable Suspicion Policy and related documents are not intended to alter my at-will employment status. I acknowledge receipt of a copy of this policy.

III. RECONOCIMIENTO DE POLIZA DE ALCOHOL Y DROGA

SPLI reconoce que el abuso de drogas y alcohol es un problema social, al igual que un problema en el lugar de trabajo. Nosotros creemos que el abuso de alcohol y el uso de drogas ilegales ponen en peligro la salud y seguridad del abusador(es) al igual que los demás en su área inmediata. SPLI esta comprometido a mantener un Programa de Sospecha Razonable Posterior al Accidente sin poner en riesgo la seguridad de empleados valiosos, pero que tiene problemas, siempre y cuando estos soliciten ayuda. Al cumplir con el Programa de Sospecha Razonable Posterior al Accidente de SPLI, como condición de empleo, requiere que el empleado se abstenga de presentarse a trabajar o que trabaje con la presencia de drogas ilegales o alcohol en su cuerpo. Esta prohibición incluye a la posesión, uso, o venta de drogas ilegales y del abuso de alcohol. Actividades socialeas realizadas por la compañía en las cuales se sirven y se consumen bebidas alcoholicas no seran consideras como abuso de alcohol solo por que se sirva alcohol Empleados, que estén en el lugar de trabajo, bajo la influenza de alcohol o drogas ilegales están violando esta póliza y pueden ser despedido. Para mantener un lugar de trabajo seguro y gratificante, es importante que trabajemos unidos cuando estemos tratando con este problema de abuso de subs

IV. EMPLOYEE ACKNOWLEDGEMENT OF THE MEDICAL PROVIDER NETWORK

Effective 04/01/2017, South East Personnel Leasing (SPLI) implemented the **Packard Medical Provider Network (MPN)**. California Law requires the employer to provide and pay for medical treatment if employees are injured at work. SPLI is pleased to provide this medical care through a Medical Provider Network approved by the California Division of Workers' Compensation. A Medical Provider Network (MPN) is a group of healthcare providers used to treat employees injured on the job. SPLI has chosen the Packard MPN to provide the most timely and suitable quality medical care for work related injuries and illnesses. The effective date of the MPN is 04/01/2017. All treatment for work related injury and illnesses on or after the effective date will be under this MPN. However, you may treat with your personal physician or medical group instead of with a MPN Physician if you properly notified SPLI prior to having an injury or illness on the predesignation of personnel physician form included in the SPLI Employment Application. The following Procedures must be followed for all work-related injuries and illnesses:

• Report promptly any work-related injury to your supervisor
• For a referral to a medical provider specialist, contact your employer or claims examiner.
• Ensure all medical treatment is handled only through the MPN
• Direct all questions about the level of care to the Primary Treating Physician (PTP), who is the focal point for all medical treatment.
• A directory of medical care providers is available at your request through your employer. You may access the Packard MPN at https://www.netbyd.com/packardmpn/ or a link is provided on SPLI's website www.spli.com and Packard Claims Administration's website www.packardclaims.com. You may also access additional copies of the MPN forms on these websites. For additional information about the MPN, assistance with accessing the network, or to alert us about an invalid provider listing, please contact the MPN Access Specialist at (877) 854-3353 or email mpninfo@netbyd.com. Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury and your duties under our Medical Provider Network.

IV. RECONOCIMIENTO DEL EMPLEADO ACERCA DEL PROVEEDOR DE SERVICIOS MEDICOS

Efectivo 04/01/2017, SouthEast Personnel Leasing (SPLI) implemento **el Proveedor Médico Packard**. La ley de California requiere que el empleador proporcione y pague por tratamiento médico si el empleado se lesiona en el trabajo. SPLI tiene la satisfacción de proveer este tratamiento médico a través de un proveedor aprobado por La Division de Compensacion Laboral del Estado de California. El Proveedor Médico es un grupo de proveedores que los empleados utilizan para la atencion medica cuando se lesionan durante el trabajo. SPLI ha escogido el Proveedor Médico Packard para proporcionar cuidado médico adecuado de las enfermedades y lesiones relacionadas con el trabajo. La fecha en que el proveedor médico se hace efectivo es 04/01/17. Todo tratamiento de lesiones y/o enfermedades relacionadas con el trabajo a partir de esta fecha, 04/01/17 se realizara utilizando este grupo proveedor médico. Sin embargo, usted puede tratarse con su propio grupo o doctor primario en lugar del proveedor médico, si usted notifica a SPLI antes de lesionarse o enfermarse a través del formulario "Designacion previa de personal médico" que esta incluido en su paquete de solicitud de empleo con SPLI. El siguiente procedimiento se debe seguir para todas lesiones y/o enfermedades relacionado con el trabajo:

• Reportar inmediatamente cualquier lesion relacionada con el trabajo a su supervisor.
• Para un remitido a un especialista médico, comuniquese con su empleador o su adjustador/a de reclamo.
• Asegurese que todo tratamiento médico se maneje solamente a través del grupo proveedor.
• Dirija todas sus preguntas acerca del nivel de atencion medica al doctor primario quien sera el punto focal de su tratamiento médico.
• Una guia de médicos proveedores puede ser proporcionada y esta disponible a traves de su empleador.

Usted puede obtener la lista de Proveedores de Packard en https://www.netbyd.com/packardmpn/ o se puede conectar al sitio del web de SPLI www.spli.com y/o Packard Claims Administration sitio del web www.packardclaims.com. Usted tambien puede obtener copias de los formularios del proveedor en estos sitios del web. Para informacion adicional del Proveedor De Servicios Médicos, asistencia con el acceso al Proveedor de Servicios Médicos o para alertarnos de un proveedor invalido, por favor comunicarse con el Proveedor De Servicios Médicos al (877) 854-3353 o por correo electronico mpninfo@netbyd.com. Por favor firme su nombre para indicar que usted ha leido y entendio el procedimiento que tiene que seguir en caso que se lesione y sus deberes bajo nuestro Proveedor De Servicios Médicos.

V. ARBITRATION AGREEMENT

Please read this document carefully. It describes how employment disputes, if any, will be handled if they cannot be resolved internally. By accepting employment, you are agreeing to the terms of this Arbitration Agreement ("Agreement"). You agree and acknowledge that South East Personnel Leasing, Inc. and subsidiaries (collectively "SPLI"), your temporary staffing employer, if any, ("Temporary Staffing Employer"), and (your "Worksite Employer"), and you will utilize binding arbitration to resolve all disputes that may arise out of the employment context. In consideration of your employment and other good and valuable consideration, including but not limited to the promises herein and the compensation and benefits paid to you, the receipt and sufficiency of which is acknowledged by the parties, the parties agree to the following terms of this Agreement.

1. "SPLI Entities" includes SPLI's past, present and future parent entities (direct or indirect), subsidiaries (direct or indirect), affiliates, legal successors, predecessors, assigns, businesses, investors, as well as the owners, directors, officers, managers, members, shareholders, principals, employees and agents of same.
2. Any dispute or claim of any kind or nature between you and SPLI, any of the applicable SPLI Entities, your Temporary Staffing Employer, or your Worksite Employer arising out of, related to, or in connection with any aspect of your employment or its termination, including but not limited to claims for breach of contract, negligence, torts, unpaid wages or other wage payment or compensation-related claims, discrimination, harassment or retaliation in violation of Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1991, 42 U.S.C. § 1981, the Age Discrimination in Employment Act of 1967, the Americans With Disabilities Act of 1990, the Family and Medical Leave Act of 1993, the Fair Labor Standards Act, the Fair Credit Reporting Act, or any other federal, state or local law, will be settled by final and binding arbitration conducted by a single, neutral arbitrator. **In agreeing to arbitrate claims, you and SPLI, the SPLI entities, your temporary staffing employer, and your worksite employer agree to waive the right to have covered disputes decided by a judge or jury.** This Agreement applies to all disputes or claims that arose before and/or after this Agreement went into effect.
3. Claims for state employment insurance benefits (e.g., unemployment compensation, workers' compensation), and any other claims that, by law, cannot be required to be resolved by binding arbitration are not covered, and thus are not subject to arbitration. In addition, this Agreement does not prevent you from filing charges with, or participating in investigations conducted by, government agencies with oversight over employment laws, including but not limited to the National Labor Relations Board and the U.S. Equal Employment Opportunity Commission. To the extent that a benefit plan specifies that a claim under the benefit plan be arbitrated under the benefit plan's arbitration process and/or procedures, then that arbitration process and/or procedures shall apply to the benefit claim.
4. The arbitration will be administered by the American Arbitration Association ("AAA") under its Employment Arbitration Rules and Mediation Procedures (including the Optional Rules for Emergency Measures of Protection), except as otherwise provided in this Agreement. These rules are available on the AAA's website located at: https://www.adr.org/.
5. Arbitration must be initiated by filing a written arbitration demand stating a description of the claim(s) and the remedy sought at any office of the AAA within the time limit established by the applicable substantive law's statute of limitations.
6. Arbitration will take place in the metropolitan area where you are or were last employed, unless prohibited by applicable law. The parties may agree to another location for the arbitration.
7. If SPLI, the SPLI Entities, your Temporary Staffing Employer, or your Worksite Employer files an arbitration claim, it will pay all arbitration fees and other forum costs charged by AAA. If you file an arbitration claim, you will pay an arbitration filing fee of $200 when the claim is filed; SPLI, the SPLI Entities, your Temporary Staffing Employer, or your Worksite Employer will pay for the remainder of the arbitration filing fees and all other arbitration forum costs charged by AAA. However, if it is determined by AAA that it would be an undue hardship on you to pay your $200 portion of the filing fee, then SPLI, the SPLI Entities, your Temporary Staffing Employer, or your Worksite Employer will pay that amount.
8. Upon a finding that a party has sustained its burden of persuasion in establishing a violation of applicable law, the arbitrator shall have the same power and authority as would a court to grant any relief, including costs and attorney's fees, in conformance with applicable principles of federal or state decisions and statutory law. The arbitrator shall issue an award in writing and state the essential findings and conclusions on which the award is based. Judgment on the award issued by the arbitrator may be entered in any court having jurisdiction.
9. The arbitrator has no authority to consolidate claims by different persons into one proceeding, nor shall the arbitrator have the power to hear an arbitration as a group, class or collective action (a group, class or collective action includes an arbitration or lawsuit where representative members of a group who claim to share a common interest seek group, class or collective relief).
10. If a party files a lawsuit in court to resolve claims subject to arbitration, the parties agree that the court shall dismiss the lawsuit and require that the claims be resolved through arbitration as provided herein.
11. **Class or collective action waiver – by entering into this agreement you and SPLI, the SPLI entities, your temporary staffing employer, and your worksite employer waive the right to commence or be party to any group, class or**

collective action claim (other than representative actions, separately addressed in paragraph 12 below) in arbitration or any other forum arising out of, related to, or in connection with any aspect of your employment and separation. The parties agree that any claim by or against you or SPLI, the SPLI entities, your temporary staffing employer, or your worksite employer will be heard on an individual basis without consolidation of such claim with any other person's or entity's claim. This provision is not applicable to the extent such waiver is prohibited by the law of the state in which you work. If this provision does not apply, the group, class or collective action claim must be litigated in a civil court of competent jurisdiction.

12. **Representative action waiver – by entering into this agreement you and SPLI, the SPLI entities, your temporary staffing employer, and your worksite employer waive the right to commence or be party to any representative action claim in arbitration or any other forum arising out of, related to, or in connection with any aspect of your employment and separation. The parties agree that any claim by or against you or SPLI, the SPLI entities, your temporary staffing employer or your worksite employer will be heard on an individual basis without consolidation of such claim with any other person's or entity's claim, including participating as a named aggrieved employee plaintiff or as an aggrieved employee member of a representative action. This provision is not applicable to the extent such waiver is prohibited by the law of the state in which you work. If this provision does not apply, the representative action claim must be litigated in a civil court of competent jurisdiction.**
13. Any party may apply to the arbitrator seeking injunctive relief until the arbitration award is rendered, or the controversy is otherwise resolved. Any party also may, without waiving any remedy under this Agreement, seek from any court having jurisdiction any interim or provisional relief that is necessary to protect the rights or property of that party, pending the appointment of the arbitrator or pending the arbitrator's determination of the merits of the controversy. While it is the intent of the parties that this Agreement be fully enforced, to the extent any judicial action is required in aid of this Agreement, the parties agree that any such action will be brought exclusively in the United Stated District Court for the district in which you are or were last employed.
14. The parties expressly acknowledge and agree that this Agreement involves interstate commerce and the interpretation and enforcement of the arbitration provisions herein will be governed by the provisions of the Federal Arbitration Act, 9 U.S.C. § 1 et seq., to the exclusion of any different or inconsistent state or local law, ordinance or judicial rule.
15. New employees must sign this Agreement as a condition of employment.
16. The SPLI Entities, your Temporary Staffing Employer, and your Worksite Employer are express third-party beneficiaries of this Agreement.
17. If for any reason the provisions of this Agreement requiring arbitration of disputes are found to be invalid, unenforceable or void, then **to the fullest extent allowed by applicable law, you and SPLI, the SPLI entities, your temporary staffing employer, and your worksite employer expressly agree to waive any right to seek or demand a jury trial and agree to have any dispute decided solely by a judge of the court.**
18. Nothing in this Agreement modifies the at will nature of your employment which can be terminated at any time, with or without cause.
19. This Agreement may be modified, in whole or in part, or terminated by SPLI only after an authorized SPLI representative provides at least 14 days' written notice of the modification or termination. The Agreement in effect at the time a claim is filed by a party will govern the process by which the claim is determined.
20. This Agreement represents the entire agreement and understanding between you and SPLI, the SPLI Entities, your Temporary Staffing Employer, and your Worksite Employer regarding the subject matter covered herein. This Agreement supersedes all prior understandings and agreements between the parties on the covered subject matter.

V. ACUERDO DE ARBITRAJE

Por favor lea cuidadosamente este documento. Describe cómo se manejarán las disputas laborales, si las hay, si no se pueden resolver internamente. Al aceptar el empleo, usted acepta los términos de este Acuerdo de Arbitraje ("Acuerdo"). Usted acepta y reconoce que South East Personnel Leasing, Inc. y sus subsidiarias (colectivamente "SPLI"), su empleador de personal temporal, si lo hubiera ("Empleador de Personal Temporal") y (su "Empleador del Lugar de Trabajo"), y usted utilizaran el arbitraje obligatorio para resolver todas las disputas que puedan surgir del contexto laboral. En consideración a su empleo y otras contraprestaciones, que incluyen pero no se limitan a las promesas incluidas en este documento y la compensación y beneficios pagados a usted, cuyo recibo y suficiencia son reconocidos por las partes, las partes acuerdan los siguientes términos de este Acuerdo.

1. Las "Entidades SPLI" incluye las entidades matrices pasadas, presentes y futuras de SPLI (directa o indirectamente), subsidiarias (directas o indirectas), afiliadas, sucesores legales, predecesores, cesionarios, negocios, inversionistas, así como los propietarios, directores, funcionarios, gerentes, miembros, accionistas. , directores, empleados y agentes de la misma.
2. Cualquier disputa o reclamo de cualquier tipo o naturaleza entre usted y SPLI, cualquiera de las Entidades SPLI aplicables, su Empleador de Personal Temporal , o su Empleador del Lugar de Trabajo que surja de, relacionado con, o en conexión con cualquier aspecto de su empleo o su terminación, incluyendo pero no limitado a reclamos por incumplimiento de contrato, negligencia, agravios, salarios no pagados u otro pago de salario o reclamos relacionados con compensación, discriminación, acoso o represalias en violación del Título VII de la Ley de Derechos Civiles de 1964, los Derechos Civiles de la Ley de 1991, 42 USC § 1981, la Ley de Discriminación por Edad en el Empleo de 1967, la Ley de Estadounidenses con Discapacidades de 1990, la Ley de Permisos Medicos y Familiares de 1993, la Ley de Normas Razonables de Trabajo, la Ley de Informes Crediticios Justos o cualquier otra ley federal, estatal o local , será resuelto por arbitraje definitivo y obligatorio realizado por un solo árbitro imparcial. **Al aceptar el arbitraje de reclamos, usted y SPLI, las entidades SPLI, su empleador de personal temporal y su empleador en el lugar de trabajo acuerdan renunciar al derecho a disputas cubiertas decididas por un juez o jurado.** Este Acuerdo se aplica a todas las disputas o reclamos que surgieron antes y / o después de que este Acuerdo entró en vigencia.
3. Los reclamos para beneficios del seguro estatal de empleo (por ejemplo, compensación por desempleo, compensación laboral) y cualquier otro reclamo que, por ley, no se pueda exigir que se resuelva mediante arbitraje obligatorio, no están cubiertos, y por lo tanto no están sujetos a arbitraje. Además, este Acuerdo no le impide presentar cargos, ni participar en investigaciones conducidas por agencias gubernamentales con supervisión sobre las leyes laborales, incluyendo, entre otros, la Junta Nacional de Relaciones Laborales y la Comisión de Igualdad de Oportunidades de Empleo de EE. UU. En la medida en que un plan de beneficios especifique que un reclamo bajo el plan de beneficios sea sometido a arbitraje según el proceso y/o procedimientos de arbitraje del plan de beneficios, entonces ese proceso de arbitraje y/o procedimientos se aplicarán al reclamo de beneficios.
4. El arbitraje será administrado por la Asociación Americana de Arbitraje ("AAA") bajo sus Reglas de Arbitraje Laboral y Procedimientos de Mediación (incluyendo las Reglas Opcionales para Medidas de Protección de Emergencia), excepto que se disponga lo contrario en este Acuerdo. Estas reglas están disponibles en el sitio web de la AAA ubicado en: https://www.adr.org/.
5. El arbitraje debe iniciarse mediante la presentación de una demanda de arbitraje por escrito que establezca una descripción de la(s) demanda(s) y el remedio solicitado en cualquier oficina de la AAA dentro del plazo establecido por el estatuto de limitaciones de la ley sustantiva aplicable.
6. El arbitraje tendrá lugar en el área metropolitana en la que está o estuvo empleado por última vez, a menos que lo prohíban las leyes aplicables. Las partes pueden acordar otro lugar para el arbitraje.
7. Si SPLI, las Entidades SPLI, su Empleador de Personal Temporal o su Empleador de Lugar de Trabajo presentan un reclamo de arbitraje, pagará todas las tarifas de arbitraje y otros costos de foro cobrados por AAA. Si usted presenta un reclamo de arbitraje, usted pagará una tarifa de presentación de arbitraje de $ 200 cuando se presente el reclamo; SPLI, las Entidades SPLI, su Empleador Temporal de Personal, o su Empleador de Lugar de Trabajo pagarán por el resto de las tarifas de presentación de arbitraje y todos los demás costos de foro de arbitraje cargados por AAA. Sin embargo, si AAA determina que sería una dificultad excesiva para usted pagar su parte de la tarifa de presentación de $ 200, entonces SPLI, las Entidades SPLI, su Empleador Temporal de Personal o su Empleador de Lugar de Trabajo pagarán esa cantidad.
8. Tras concluir que una parte ha soportado su carga de persuasión al establecer una violación de la ley aplicable, el árbitro tendrá el mismo poder y autoridad que un tribunal para otorgar cualquier alivio, incluidos los costos y honorarios de abogados, de conformidad con los principios aplicables de decisiones federales o estatales y la ley estatutaria. El árbitro emitirá una sentencia por escrito e indicará los hallazgos y conclusiones esenciales en los que se basa la sentencia. El fallo sobre la sentencia emitida por el árbitro se puede ingresar en cualquier tribunal que tenga jurisdicción.
9. The El árbitro no tiene autoridad para consolidar reclamos de diferentes personas en un solo procedimiento, ni el árbitro tendrá la facultad de escuchar un arbitraje como grupo, clase o acción colectiva (un grupo, clase o acción colectiva incluye un arbitraje o demanda donde los miembros representativos de un grupo que dice compartir un interés común, busca alivio grupal, de clase o colectivo).
10. Si una de las partes presenta una demanda ante el tribunal para resolver reclamos sujetos a arbitraje, las partes acuerdan que el tribunal desestimará la demanda y exigirá que los reclamos se resuelvan mediante el arbitraje según lo dispuesto en este documento.
11. **Renuncia de acción de clase o colectiva: al celebrar este acuerdo usted y SPLI, las entidades SPLI, su empleador temporal de personal y su empleador de lugar de trabajo renuncian al derecho de comenzar o ser parte de un reclamo de accion de grupo, clase o colectiva (que no sean acciones representativas, abordadas por separado en el párrafo 12 a continuación) en arbitraje o en cualquier otro foro que surja de, relacionado con, o en conexión con, cualquier aspecto de su empleo y separación. Las partes acuerdan que cualquier reclamo por o en contra de usted o SPLI, las entidades SPLI, su empleador temporal de personal y su empleador de lugar de trabajo será escuchado de manera individual sin la consolidación de dicho reclamo con el reclamo de otra persona o entidad. Esta disposición no es aplicable en la medida en que dicha renuncia esté prohibida por la ley del estado en el cual usted trabaja. Si esta disposición no se aplica, el reclamo de grupo, clase o acción colectiva debe ser litigado en un tribunal civil de la jurisdicción competente.**
12. **Renuncia de acción representativa – al celebrar este acuerdo usted y SPLI, las entidades SPLI, su empleador temporal de personal y su empleador de lugar de trabajo renuncian al derecho de comenzar o ser parte de un reclamo de accion de grupo, clase o colectiva en arbitraje o en cualquier otro foro que surja de, relacionado con, o en conexión con, cualquier aspecto de su empleo y separación. Las partes acuerdan que cualquier reclamo por o en contra de usted o SPLI, las entidades SPLI, su empleador temporal de personal y su empleador de lugar de trabajo será escuchado de manera individual sin la consolidación de dicho reclamo con el reclamo de otra persona o entidad, incluida la participación como empleado agraviado demandante o como un empleado agraviado miembro de una acción representativa. Esta disposición no es aplicable en la medida en que dicha renuncia esté prohibida por la ley del estado en el cual usted trabaja. Si esta disposición no se aplica, el reclamo de grupo, clase o acción colectiva debe ser litigado en un tribunal civil de la jurisdicción competente.**
13. Cualquiera de las partes puede solicitar al árbitro que solicita una medida cautelar hasta que se dicte la sentencia de arbitraje, o la controversia se resuelva de otra manera. Cualquiera de las partes puede, sin renunciar a ningún recurso bajo este Acuerdo, solicitar a cualquier tribunal competente cualquier alivio provisional o interino que sea necesaria para proteger los derechos o propiedad de esa parte, en espera del nombramiento del árbitro o en espera de la determinación del árbitro de los méritos de la controversia. Si bien la intención de las partes es que este Acuerdo se cumpla por completo, en la medida en que se requiera una acción judicial en ayuda de este Acuerdo, las partes acuerdan que dicha acción se presentará exclusivamente en el Tribunal de Distrito de Estados Unidos en el distrito en el cual usted este o estuvo empleado por último vez.
14. Las partes expresamente reconocen y aceptan que este Acuerdo implica comercio interestatal y la interpretación y cumplimiento de las disposiciones de arbitraje en este documento se regirán por las disposiciones de la Ley Federal de Arbitraje, 9 U.S.C. § 1 et seq., con exclusión de cualquier ley, ordenanza o norma judicial estatal

o estatal diferente o inconsistente.

15. Los nuevos empleados deben firmar este Acuerdo como una condición de empleo.
16. Las Entidades SPLI, su Empleador Temporal de Personal, o su Empleador de Lugar de Trabajo son expresamente terceros beneficiarios de este Acuerdo.
17. Si por alguna razón las disposiciones de este Acuerdo que requieren arbitraje de disputas son inválidas, inaplicables o nulas, entonces, **en la máxima medida permitida por la ley aplicable, usted, las entidades SPLI, su empleador temporal de personal, o su empleador de lugar de trabajo aceptan expresamente renunciar a cualquier derecho a solicitar o exigir un juicio con jurado y acuerdan que cualquier disputa sea decidida únicamente por un juez del tribunal**.
18. Nada en este Acuerdo modifica la naturaleza a voluntad de su empleo que puede rescindirse en cualquier momento, con o sin causa.
19. Este Acuerdo puede ser modificado, en su totalidad o en parte, o rescindido por SPLI solo después de que un representante autorizado de SPLI proporcione al menos 14 días de aviso por escrito de la modificación o terminación. El Acuerdo vigente en el momento en que un reclamo es presentado por una parte regirá el proceso por el cual se determina el reclamo.
20. Este Acuerdo representa la totalidad del acuerdo y entendimiento entre usted y SPLI, las Entidades SPLI, su Empleador Temporal de Personal y su Empleador de Lugar de Trabajo con respecto al tema tratado en este documento. Este Acuerdo reemplaza todos los convenios y acuerdos previos entre las partes sobre el tema tratado.

SPLI

By: 

Its: Director, Human Resources and Benefits

I have read, or had read to me, and understand the I. APPLICANT AGREEMENT, II. USE OF PERSONAL PROTECTIVE EQUIPMENT, III. ACKNOWLEDGMENT OF ALCOHOL AND DRUG POLICY, and IV. EMPLOYEE ACKNOWLEDGEMENT OF THE MEDICAL PROVIDER NETWORK, and V. ARBITRATION AGREEMENT.

He leído, o se me ha leído, y comprendo el I. RECONOCIMIENTO DEL SOLICITANTE, II. USO DE EQUIPO DE PROTECCION PERSONAL, III. RECONOCIMIENTO DE POLIZA DE ALCOHOL Y DROGA, IV. RECONOCIMIENTO DEL EMPLEADO ACERCA DEL PROVEEDOR DE SERVICIOS MEDICOS y V. ACUERDO DE ARBITRAJE.

AGREED and ACCEPTED as of (ACORDADO y ACEPTADO a partir de)_____
Date (Fecha)

_____
Applicant's Printed Name (Nombre Impreso del Solicitante)

_____
Applicant's Signature (Firma del Solicitante)

SOUTHEAST PERSONNEL LEASING, INC.

DEDUCTION AUTHORIZATION (AUTORIZACION DE DEDUCCIÓN)

Employee Name (Nombre): _____ SSN (Número de Seguridad Social): _____

Client Name (Compañia del Cliente): _____

Benefits Deductions (Deducciones para Beneficios)

	Check One (marque uno)	Insurance Company Name or 3rd Party Administrator (Nombre de la compañía de seguros o administrador del plan)	Type of Deduction Health/Dental/401k/ Roth/Simple IRA (Tipo de Deducción)	Deduction Begin Date (Fecha de Comienzo)	Amount or Percentage per Pay Period (Cantidad por Período de Paga)		
					Pre-Tax Amount or Post-Tax Amount		Balance, if any
1	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)						
2	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				Pre-Tax Amount or Post-Tax Amount		Balance, if any
3	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				Pre-Tax Amount or Post-Tax Amount		Balance, if any
4	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				Pre-Tax Amount or Post-Tax Amount		Balance, if any
5	○ New Deduction (Nueva) ○ Change Current Amount (Camio) ○ Add to Current Amount (Incrementar)				Pre-Tax Amount or Post-Tax Amount		Balance, if any

***Child Support (CS) Deductions** ○ **Yes, I have CS deductions** ○ **No, I do not have CS deductions** **Initials** (Iniciales): _____

*(Deducciones de Manutención) (Sí, tengo deducciones de Manutención) (No, no tengo deducciones de Manutención

	State of Order (Estado de Orden)	Case # (Caso #)	Address for Distribution (Dirección para distribución)	Amount Per Pay Period (Cantidad por Período de Paga)
1				
2				
3				
4				
5				

***Child Support Order(s) MUST be attached** (*La orden de manutención debe estar adjunta)

Payroll Deductions ○ **Yes, I have payroll deductions** ○ **No, I do not have payroll deductions** **Initials** (Iniciales): _____

(Deducciones de Nómina) (Sí, tengo deducciones de nómina) (No, no tengo deducciones de nómina)

	Type of Deduction (Uniform, Loan, Advance, etc.) (Tipo de deduccion: uniforme, prestamo, adelanto, etc.)	Payroll Commencement Date (Fecha de Comienzo de Nomina)	Total Amount of Deduction (Cantidad Total De Deucción)	Amount Per Pay Period (Cantidad por Periodo de Paga)
1				
2				
3				
4				
5				

I hereby authorize SPLI to make the above deductions from my pay in accordance with the above terms. I understand and agree that I am responsible for satisfying the above amounts. I further understand and agree that deductions will be made after any federal or state requirements as well as for any SPLI or Client Company programs in which I have enrolled, for which I am eligible, or to which I have agreed. Por este medio autorizo a SPLI a hacer las susodichas deducciones de mi paga de acuerdo con los susodichos terminos. Entiendo y estoy de acuerdo que soy responsable de satisfacer las susodichas cantidades. Comprendo aún más y concuerdo que deducciones serán hechas después de cualquier exigencia federal o estatal así como para cualquier SPLI o Compañia del Cliente programas en los cuales me he matriculado, por los que soy elegible, o con que he estado de acuerdo.

Employee Signature (Firma del Solicitante): _____ **Date** (Fecha): _____

Client Signature (Firma del cliente): _____ **Date** (Fecha): _____

PREDESIGNATION OF PERSONAL PHYSICIAN *(DESIGNACIÓN PREVIA DE MÉDICO PARTICULAR)*

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.), 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, or 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.

En caso de que usted sufra una lesión o enfermedad relacionada a su empleo, usted puede recibir tratamiento médico por esa lesión o enfermedad de su médico personal (M.D.), médico osteópata (D.O.) o grupo médico si:

- *en la fecha de su lesión laboral usted tiene cobertura de atención médica para lesiones o enfermedades no laborales;*
- *el médico es su médico regular, que será o un médico que ha limitado su práctica médica a medicina general o un internista certificado o elegible para serlo, pediatra, gineco-obstetra, o médico de medicina familiar y que previamente ha estado a cargo de su tratamiento médico y tiene su expediente médico;*
- *su "médico personal" puede ser un grupo médico si es una corporación o sociedad o asociación compuesta de doctores certificados en medicina u osteopatía, que opera un grupo médico multidisciplinario integrado que predominantemente proporciona amplios servicios médicos para lesiones y enfermedades no laborales;*
- *antes de la lesión su médico está de acuerdo a proporcionarle tratamiento médico para su lesión o enfermedad de trabajo;*
- *antes de la lesión usted le proporcionó a su empleador por escrito lo siguiente:(1) notificación de que quiere que su médico personal lo trate para una lesión o enfermedad laboral y (2) el nombre y dirección comercial de su médico personal.*

Puede usar este formulario para notificarle a su empleador si usted desea que su médico personal o médico osteópata lo trate para una lesión o enfermedad de trabajo y que los requisitos mencionados arriba se cumplan.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN *(NOTICIA DE DESIGNACIÓN PREVIA DE MÉDICO PARTICULAR)*

Employee: Complete this section. *(Empleado: Rellene esta sección)*

To (*A*): _____ (name of employer - *nombre del empleador*). If I have a work-related injury or illness, I choose to be treated by (*Si sufro una lesión o enfermedad laboral, yo elijo recibir tratamiento médico de*):

_____

(name of doctor)(M.D., D.O., or medical group) - (*nombre del médico)(M.D., D.O., o grupo médico*)

_____ (street address, city, state, ZIP - *dirección, ciudad, estado, código postal*)

_____ (telephone number - *número de teléfono*)

Employee Name (please print) - *Nombre del Empleado (en letras de molde, por favor)*: _____

Employee's Address *(Dirección del Empleado)*: _____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses *(Nombre de Compañía de Seguros, Plan o Fondo proporcionando cobertura médica para lesiónes o enfermedades no laborales)*:

_____

Employee's Signature *(Firma del Empleado)*: _____ Date *(Fecha)*: _____

Physician: I agree to this Predesignation *(Médico: Estoy de acuerdo con esta Designación Previa)***:**

Signature *(Firma)*: _____ Date *(Fecha)*: _____
(Physician or Designated Employee of the Physician or Medical Group)
(Médico o Empleado designado por el Médico o Grupo Médico)

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. *El médico no está obligado a firmar este formulario, sin embargo, si el médico o empleado designado por el médico o grupo médico no firma, será necesario presentar documentación sobre el consentimiento del médico de ser designado previamente de acuerdo al Código de Reglamentos de California, Título 8, sección 9780.1(a)(3)*. Título 8, Código de Reglamentos de California, sección 9783.

HIREtech, an Equifax Company			
Account Name	Tax ID (FEIN)	Employer Code	Start Date
SouthEast Personnel Leasing, Inc.	59-3298197	4241333	

TAX CREDIT QUESTIONNAIRE

This form is used to identify federal tax credits and is NOT intended to determine your work eligibility.

TO BE COMPLETED BY EMPLOYEE (Please Print Clearly)

First Name	Last Name	SSN

Home Address	Date of Birth

City	State	Zip Code	County

Job Title	Have You Worked for this Company Before?	Driver's License or State ID Number	State
	○ YES ○ NO		

1. Within the past 2 years, have you or a member of your household received any form of cash or voucher assistance, such as Food Stamps (SNAP) or Temporary Assistance for Needy Families (TANF)? ○ **YES** ○ **Not Sure** ○ **NO**

If YES or Not Sure, please provide the following information:

Primary Recipient (Name and Social Security Number)	Relation to Yourself	City/ State Where Received

Assistance Type: (Check all that apply)	Date First Received (MM/YY)	Date Last Received (MM/YY)
○ Food Stamps (SNAP) ○ TANF		

2. Have you ever served on active duty in the US Military? ○ **YES** ○ **Not Sure** ○ **NO**

If YES or Not Sure, please provide the following information:

2b. Are you eligible to receive compensation for a service connected disability? ○ Yes ○ No	Date Entered (MM/YY)
Branch of Service: ○ Army ○ Navy ○ Air Force ○ Marines ○ Coast Guard ○ National Guard	Discharge Date (MM/YY)

3. Have you ever been convicted of a felony? (Do NOT include misdemeanors) ○ **YES** ○ **Not Sure** ○ **NO**

If YES or Not Sure, please provide the following information:

Parole/ Probation Officer Name	Parole/ Probation Officer Phone Number	Date Convicted (MM/YY)	Date Released (MM/YY)

Offense Type: ○ State ○ Federal	City/State of Conviction	County of Conviction

4. Have you ever participated in a State or Veterans Affairs Vocational Rehabilitation Program or have you participated in the Ticket to Work program? ○ **YES** ○ **Not Sure** ○ **NO**

If YES or Not Sure, please provide the following information:

Agency Name/Rehabilitation Program/Employment Network	Date Completed (MM/YY)

Agency City	Agency State	Agency Phone Number

Program type: ○ Vocational Rehabilitation ○ Veterans Affairs ○ Ticket to Work

5. Have you received Supplemental Security Income (SSI) benefits for yourself within the last 3 months? Do NOT include Social Security Disability Income (SSDI). ○ **YES** ○ **Not Sure** ○ **NO**

If YES or Not Sure, please provide the following information: Date Last Received (MM/YY) _____

6. Have you been unemployed, received Unemployment Benefits or been eligible to receive Unemployment Benefits during the past year? ○ **YES** ○ **Not Sure** ○ **NO**

If YES or Not Sure, please provide the following information:

How many months in the past year were you unemployed? _____

What was your last day of work with your previous employer? (MM/DD/YY) _____

Did you receive unemployment compensation? **O Yes O No** In what state did you receive unemployment compensation?

EMPLOYEE DECLARATION AND RELEASE

By signing this voluntary form, I hereby authorize the release to Equifax Workforce Solutions or its agents information held by any parties needed to determine my eligibility for federal and/or state tax credit programs. This includes, but is not limited to, information regarding my criminal history, driver records, military service, SSI benefits, vocational rehabilitation services, unemployment benefits, AFDC/TANF benefits or Food Stamp benefits. I further authorize Equifax Workforce Solutions or its agents to complete on my behalf any forms required to obtain this information, including SSA Form 3288.

Employee Signature: _____ **Date:** _____

4241333 SouthEast Personnel Leasing, Inc. 59-3298197

Form **8850** (Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

► **Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.***

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

---

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► **Date**

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: May 31, 2026

Work Opportunity Tax Credit
LONG-TERM UNEMPLOYMENT RECIPIENT (LTUR)
SELF-ATTESTATION FORM (SAF)

Instructions: The Self-Attestation Form (SAF) is to be completed, signed, and dated by the applicant / new hire, only. Employers or their authorized representatives should submit the completed SAF along with IRS Form 8850, *Pre-Screening Notice and Certification Request for the Work Opportunity Tax Credit*, or if filed separately, with ETA Form 9061/ETA Form 9062, to the State Workforce Agency (SWA) for each certification request submitted for the Long-Term Unemployment Recipient (LTUR) targeted group.

Applicant Self-Attestation: Under penalties of perjury, I declare that the information below is true and correct to the best of my knowledge.

Applicant's Full Name (Print: *First, Middle Initial, Last*): _____

Applicant's Signature: _____ **Date**: _____

Applicant's Social Security Number: _____ **Date of Birth**:(mm/dd/yyyy) _____

Employer's Name: _____

Employer's Firm/Company Name: SouthEast Personnel Leasing, Inc.

Applicant Instructions: Please check "√" the statement below if it applies to you and fill in the requested information below.

☐ I declare that I was/am in a period of unemployment that was/is at least 27 consecutive weeks; **and**, for all or part of that unemployment period, I received unemployment compensation under State or Federal law.

State(s) unemployment compensation was received: _____.

I have been in a period of unemployment since (Enter unemployment start date: mm/dd/yyyy)_____

Privacy Act Notice:
Section 51 of the Internal Revenue Code of 1986, as amended, and its enacting legislation (P.L. 104-188), specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification process. The information you have provided by completing this Form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however, the information is required to determine your employer's eligibility for the federal work opportunity tax credit.

Public Burden Statement:
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this Form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Act – OMB Control No. 1205-0371). Please do not submit completed WOTC processing forms to this address.

Welcome to the Packard MPN

California law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer or insurer has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). This MPN is administered by Networks By Design, Inc. This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work-related injuries and illnesses.

What MPN is used by my employer?

Your employer or insurer is using the Packard MPN with the identification number 3013. You must refer to the MPN name and the MPN identification number whenever you have questions or requests about the MPN.

▪ What is an MPN?

A Medical Provider Network (MPN) is a group of health care providers (physicians and other medical providers) used by your employer or insurer to treat workers injured on the job. MPNs must allow employees to have a choice of provider(s). Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine.

The MPN Medical Access Assistant will help you find available MPN physicians of your choice and can assist you with scheduling and confirming physician appointments. The Medical Access Assistant is available to assist you Monday through Saturday from 7am-8pm (Pacific) and schedule medical appointments during doctor's' normal business hours. Assistance is available in English and in Spanish.

The contact information for the Medical Access Assistant is:

Toll Free Telephone Number: (877)854-3353
Fax Number: (209) 879-9387
Email Address: mpninfo@netbyd.com

▪ What happens if I get injured at work?

In case of an emergency, you should call 911 or go to the closest emergency room.

If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer that you have had a work-related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

Important Information about Medical Care if You Have a Work-Related Injury or Illness

Complete Written Employee Notification Re: Medical Provider Network
(Title 8, California Code of Regulations, section 9767.12)

Keep this information in case you have a work-related injury or illness.

Packard Claims Administration Inc.

▪ Who can I contact if I have questions about my MPN?

The MPN Contact listed in this notification will be able to answer your questions about the use of the MPN and will address any complaints regarding the MPN.

The contact for your MPN is:

Name: Networks By Design, Inc.
Title: MPN Contact
Address: P.O. Box 820, Tracy, California 95378
Telephone Number: (877) 854-3353
Email address: mpninfo@netbyd.com

General information regarding the MPN can also be found at the following website:
https://www.netbyd.com/packardmpn/

▪ How do I find out which doctors are in my MPN?

You can get a regional list of all MPN providers in your area by calling the MPN Contact or by going to our website at: https://www.netbyd.com/packardmpn/. At minimum, the regional list must include a list of all MPN providers within 15 miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive. You also have the right to obtain a list of all the MPN providers upon request.

You can access the roster of all treating physicians in the MPN by going to the website at: https://www.netbyd.com/packardmpn/.

▪ How do I choose a provider?

Your employer or the insurer for your employer will arrange the initial medical evaluation with a MPN physician. After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. Some specialists will only accept appointments with a referral from the treating doctor. Such specialists might be listed as "by referral only" in your MPN directory.

If you need help in finding a doctor or scheduling a medical appointment, you may call the Medical Access Assistant.

▪ Can I change providers?

Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact the MPN Contact or your claims adjuster if you want to change your treating physician.

▪ What standards does the MPN have to meet?

The MPN has providers for the entire State of California.

The MPN must give you access to a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The MPN must provide access to primary treating physicians within 30 minutes or 15 miles and specialists within 60 minutes or 30 miles of where you work or live.

If you live in a rural area or an area where there is a health care shortage, there may be a different standard.

After you have notified your employer of your injury, the MPN must provide initial treatment within 3 business days. If treatment with a specialist has been authorized, the appointment with the specialist must be provided to you within 20 business days of your request.

If you have trouble getting an appointment with a provider in the MPN, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and time frame requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

▪ What if there are no MPN providers where I am located?

If you are a current employee living in a rural area or temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area, the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your own doctor outside of the MPN network. Contact your MPN Contact for assistance in finding a physician or for additional information.

▪ What if I need a specialist that is not available in the MPN?

If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside of the MPN.

▪ What if I disagree with my doctor about medical treatment?

If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN Contact or your claims adjuster and tell them you want a second opinion.

The MPN should give you at least a regional or full MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within 60 days. You must tell the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You may also request a copy of your medical records that will be sent to the doctor.

If you do not make an appointment within 60 days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of the treating physician.

If the second-opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.
Remember that if you do not make an appointment within 60 days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If you disagree with the third-opinion doctor, you may ask for an MPN Independent Medical Review (MPN IMR). Your employer or MPN Contact will give you information and a form for requesting a MPN Independent Medical Review at the time you select a third-opinion physician.

If either the second or third-opinion doctor or MPN Independent Medical Reviewer agrees with your need for a treatment or test, you may be allowed to receive that medical service from a provider within the MPN, or if the MPN does not contain a physician who can provide the recommended treatment, you may choose a physician outside the MPN within a reasonable geographic area.

▪ What if I am already being treated For a work-related injury before the MPN begins?

Your employer or insurer has a "Transfer of Care" policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician. However, if you have properly predesignated a primary treating physician, you cannot be transferred into the MPN. (If you have questions about predesignation, ask your supervisor.)

If your employer decides to transfer you into the MPN, you and your primary treating physician must receive a letter notifying you of the transfer.

If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the MPN. The qualifying conditions to postpone the transfer of your care into the MPN are set forth in the box below.

▪ Can I Continue Being Treated By My Doctor?

You may qualify for continuing treatment with your non-MPN provider (through transfer of care or continuity of care) for up to a year if your injury or illness meets any of the following conditions:

(Acute) The treatment for your injury or illness will be completed in less than 90 days;
(Serious or Chronic) Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made;
(Terminal) You have an incurable illness or irreversible condition that is likely to cause death within one year or less;
(Pending Surgery) You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

You can disagree with your employer's decision to transfer your care into the MPN. If you don't want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to qualify for a postponement of your transfer into the MPN.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within 20 days of your request, the employer can transfer your care into the MPN and you will be required to use an MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the transfer of your care. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Transfer of Care policy for more details on the dispute resolution process.

For a copy of the Transfer of Care policy, in English or Spanish, ask your MPN Contact.

▪ What if I am being treated by a MPN doctor who decides to leave the MPN?

Your employer or insurer has a written "Continuity of Care" policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

If your employer decides that you do not qualify to continue your care with the non-MPN provider, you and your primary treating physician must receive a letter notifying you of this decision.

If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must choose a MPN physician. These conditions are set forth in the "Can I Continue Being Treated By My Doctor?" box above.

You can disagree with your employer's decision to deny you Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the box above to see if you qualify to continue treating with your current doctor temporarily.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her medical report on your condition. If your primary treating physician does not give you the report within 20 days of your request, your employer's decision to deny you Continuity of Care with your doctor who is no longer participating in the MPN will apply, and you will be required to choose a MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the selection of another MPN doctor for your continued treatment. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Continuity of Care policy for more details on the dispute resolution process. For a copy of the Continuity of Care policy, in English or Spanish, ask your MPN Contact.

▪ What if I have questions or need help?

MPN Contact: You may always contact the MPN Contact if you have questions about the use of the MPN and to address any complaints regarding the MPN.
Medical Access Assistants: You may contact the Medical Access Assistant if you need help finding MPN physicians and scheduling and confirming appointments.
Division of Workers' Compensation (DWC): If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you may call the DWC Information and Assistance office at 1-800-736-7401. You may also go to the DWC website at www.dir.ca.gov/dwc and under the header "Workers compensation programs and units" click on "Medical provider networks" for more information about MPNs.

MPN Independent Medical Review: If you have questions about the MPN Independent Medical Review process, contact the Division of Workers' Compensation's Medical Unit at:

DWC Medical Unit
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900.

Bienvenido a Packard MPN

La ley de California requiere que su empleador le proporcione y pague el tratamiento médico si se lesiona en el trabajo. Su empleador o asegurador ha elegido a proporcionar este cuidado médico utilizando una red de médicos de Compensación de Trabajadores llamada Red de Proveedores Médicos o MPN (Medical Provider Network). Esta MPN está administrada por Networks By Design, Inc. Esta notificación le informará lo que necesita saber sobre el programa de la MPN y le describirá sus derechos en elegir cuidado médico para sus lesiones o enfermedades de trabajo.

¿Qué es una MPN usado por mi empleador?

Su empleador o asegurador está usando Packard MPN con número de identificación 3013. Usted debe referirse al nombre y número de identificación de la MPN cuando tenga preguntas o peticiones acerca de la MPN.

▪ ¿Qué es una MPN?

Una Red de Proveedores Médicos o MPN es un grupo de proveedores de asistencia médica usados por su empleador (médicos y otros proveedores médicos) utilizados por su empleador o asegurador para atender a trabajadores que se lesionan en el trabajo. Cada MPN debe incluir una combinación de médicos que se especializan en lesiones de trabajo y médicos expertos en áreas de medicina general.

El Asistente de Acceso Médico de la MPN le ayudará a encontrar un médico de la MPN disponible de su elección y puede asistirle en hacer y confirmar una cita médica. El Asistente de Acceso Médico está disponible de Lunes a Sábado de 7am- 8pm (Pacífico) y a programar citas médicas durante las horas de las oficinas médicas. La asistencia está disponible en Inglés y Español.

La información de contacto para el Asistente de Acceso Médico es:
Número de teléfono gratuito: (877)854-3353
Número de Fax: (209) 879-9387
Correo Electrónico: mpninfo@netbyd.com

▪ ¿Qué pasa si me lastimo en el trabajo?

En caso de emergencia, debe llamar al 911 o ir a la sala de emergencias más cercana.

Información Importante sobre Cuidado Médico si tiene una Lesión o Enfermedad de Trabajo

Completa Notificación Inicial Escrita del Empleado sobre la Red de Proveedores Médicos
(Título 8, Código de Regulaciones de California, sección 9767.12)

Mantenga esta información en caso de una lesión o enfermedad relacionada con el trabajo.

Si se lesiona en el trabajo, notifique a su empleador lo más pronto posible. Su empleador le proporcionará un formulario de reclamo. Cuando le notifique a su empleador que ha sufrido una lesión de trabajo, su empleador hará la cita inicial con el médico de la MPN.

▪ ¿Cómo puedo averiguar cuáles médicos pertenecen a mi MPN?

El Contacto de la MPN enlistado en esta notificación podrá contestar sus preguntas sobre cómo usar el MPN y resolverá cualquier queja respecto a el MPN.

El contacto para el MPN es:
Nombre: Networks By Design, Inc.
Título: MPN Contact
Dirección: P.O. Box 820, Tracy, California 95378
Numero telefónico: (877) 854-3353
Correo electrónico: mpninfo@netbyd.com

Información General respecto a la MPN también puede ser encontrada en la siguiente página de la red https://www.netbyd.com/packardmpn/

▪ ¿Cómo averiguo cuáles proveedores médicos son parte de la MPN?

Usted puede obtener una lista regional de los proveedores de la MPN en su área llamando al contacto de la MPN o visitando nuestro sitio web en: https://www.netbyd.com/packardmpn/. Como mínimo, la lista regional debe incluir una lista de todos los proveedores de la MPN dentro de 15 millas de su lugar de trabajo y / o residencia o una lista de todos los proveedores de la MPN dentro del condado donde usted vive y / o trabaja. Usted puede elegir qué lista quiere recibir. Usted también tiene el derecho de obtener una lista de todos los proveedores de la MPN que lo soliciten.

Puede acceder a la lista de todos los médicos tratantes en el MPN por ir a la página web en: https://www.netbyd.com/packardmpn/.

▪ ¿Cómo escojo un proveedor?

Su empleador o la aseguradora de su empleador arreglara la evaluación médica inicial con un médico de la MPN. Después de la primera visita médica, puede continuar ser atendido por este médico o puede elegir otro médico dentro de la MPN. Puede continuar eligiendo médicos de la MPN para todo su cuidado médico para esta lesión. Si es apropiado, puede escoger un especialista o puede pedirle al médico que lo está atendiendo que lo refiera a un especialista. Si necesita ayuda en elegir un médico puede llamar al contacto de la MPN arriba descrito. Algunos especialistas solo aceptarán citas con una referencia del médico tratante. Dicho especialista puede ser enlistado como "por referencia solamente" en el directorio de la MPN.

Si necesita ayuda para encontrar un doctor o hacer una cita médica, puede llamar al Asistente de Acceso Médico.

▪ ¿Puedo cambiar de proveedor?

Sí. Usted puede cambiar de proveedores dentro de la MPN por cualquier razón, pero los proveedores que elija deben ser apropiados para tratar su lesión. Contacte al contacto de la MPN o a su ajustador de reclamos si desea cambiar su médico tratante.

▪ ¿Qué requisitos debe tener la MPN?

La MPN tiene proveedores en todo el Estado de California.

La MPN tiene que proporcionarle acceso a una lista regional de proveedores que incluya por lo menos tres médicos en cada especialidad usualmente utilizada para tratar lesiones/enfermedades en su industria. La MPN debe proporcionarles acceso a médicos primarios, Médicos que tratan dentro de 30 minutos o 15 millas y especialistas dentro de 60 minutos o 30 millas de distancia de donde usted vive o trabaja. Si usted vive en una área rural o en una área donde hay un cuidado médico escaso, puede ser un estándar diferente.

Después de haber notificado a su empleador sobre su lesión, la MPN debe proporcionar tratamiento inicial dentro de 3 días. Si el tratamiento con un especialista ha sido autorizado, la cita con el especialista debe de ser proveída dentro de 20 días de negocio desde su pedido.

Si tiene dificultad para conseguir una cita con un proveedor de la MPN, contacte al Asistente de Acceso Médico.

Si no hay proveedores de la MPN en la especialidad apropiada disponibles a tratar su lesión dentro de la distancia y tiempos requeridos, entonces se le permitirá buscar el tratamiento necesario fuera de la MPN.

▪ ¿Qué tal si no hay proveedores de la MPN donde estoy localizado?

Si está temporalmente trabajando o viviendo fuera de la área de servicio de la MPN o en una área rural, la MPN o el médico que lo está atendiendo le dará una lista de por lo menos tres médicos que lo puedan atender. La MPN también puede permitirle elegir su propio médico fuera de la red de la MPN. Póngase en contacto con su contacto de la MPN para asistencia en encontrar un médico o para información adicional.

▪ ¿Qué tal si necesito un especialista que no está dentro de la MPN?

Si necesita ver un especialista que no está disponible dentro de la MPN, usted tiene derecho a ver un especialista fuera de la MPN.

▪ ¿Qué tal si no estoy de acuerdo con mi médico sobre tratamiento médico?

Si usted no está de acuerdo con su médico o desea cambiar de médico por cualquier razón, usted puede escoger otro médico dentro de la MPN.

Si usted no está de acuerdo con el diagnosis o tratamiento recetado por su médico, usted puede pedir una segunda opinión de un médico dentro de la MPN. Si quiere una segunda opinión, debe ponerse en contacto con la MPN, contacte a su ajustador de reclamos y dígale que quiere una segunda opinión. La persona de contacto asegurará que por lo menos tenga una lista regional o completa de proveedores de la MPN para elegirlo. Para obtener una segunda opinión, debe elegir un médico dentro de la lista de la MPN y hacer una cita dentro de 60 días. Usted debe decirle al contacto de la MPN la fecha de su

cita y el contacto de la MPN le mandará al médico una copia de su expediente médico. Usted puede pedir una copia de su expediente

Si el médico de la segunda opinión siente que su lesión está fuera del tipo de lesión que él o élla normalmente trata, la oficina del médico le notificará a su empleador o compañía de seguros y usted obtendrá otra lista de médicos o especialistas de la MPN para que pueda hacer otra selección.

Si usted no está de acuerdo con la segunda opinión, puede pedir por una tercera opinión. Si usted pide una tercera opinión, usted pasará por el mismo proceso que pasó para la segunda opinión.

Recuerde que si no hace una cita dentro de 60 días a partir de recibir la otra lista de proveedores de la MPN, entonces no le será permitido tener una tercera opinión sobre el disputado diagnóstico o tratamiento recomendado por el médico que lo está atendiendo.

Si usted no está de acuerdo con el médico de la tercera opinión, usted puede pedir una MPN Revisión Médica Independiente o MPN IMR (MPN Independent Medical Review). Su empleador o el contacto de la MPN le dará información sobre cómo pedir la MPN Revisión Médica Independiente y un formulario cuando usted selecciona la tercera opinión médica.

Si el médico o MPN Revisor Médico Independiente de la segunda o tercera opinión está de acuerdo que usted necesita algún tratamiento o análisis, le será tal vez permitido recibir el servicio médico de un proveedor dentro de la MPN, o si la MPN no tiene un médico quien puede proveer el tratamiento, puede elegir a un médico fuera de la MPN dentro de una área geográfica razonable.

▪ ¿Qué tal si ya estoy siendo atendido por una lesión de trabajo antes de que empiece el MPN?

Su empleador o la compañía de seguros tienen un plan de "Transferencia de Cuidado" que determinará si usted puede continuar siendo temporalmente atendido por una lesión de trabajo por un médico fuera de la MPN antes de que su cuidado sea transferido a la MPN.

Si su médico actual no es o no se convierte en un miembro de la MPN, entonces podrá ser obligado a ver a un médico de la MPN. Sin embargo, si usted apropiadamente ha designado previamente un médico para atenderlo, usted no puede ser

médico que se le enviará al médico.

Si no hace una cita dentro de 60 días a partir de recibir la lista regional de proveedores, no le será transferido a la MPN. (Si tiene preguntas acerca de la designación previa, pregúntele a su supervisor.)

Si su empleador decide transferirlo a la MPN, usted y su médico que lo está atendiendo deben recibir una carta notificándoles de la transferencia.

Si usted llena ciertos requisitos, pueda que califique a continuar ser atendido por un médico fuera de la MPN hasta por un año antes de que sea transferido a la MPN. Los requisitos para posponer la transferencia de su cuidado a la MPN están expuestos en la caja debajo.

▪ ¿Puedo Continuar Ser Tratado Por Mi Médico?

Usted puede calificar para tratamiento continuo con su proveedor que no está dentro de la MPN (por transferencia de cuidado o continuidad de cuidado) hasta por un año si su lesión o enfermedad llena cualquiera de las siguientes condiciones:

(Agudo) El tratamiento para su lesión o enfermedad será completado en menos de 90 días;

(**Grave o crónico)** Su lesión o enfermedad es una que es grave y continua por lo menos 90 días sin una cura total o empeora y requiere de tratamiento continuo. Se le podrá permitir ser tratado por su médico actual hasta por un año, hasta que una transferencia de cuidado segura pueda ser hecha;

(Terminal) Tiene una enfermedad incurable o condición irreversible que probablemente cause la muerte dentro de un año o menos;

(Cirugía pendiente) Ya tiene una cirugía u otro procedimiento que ha sido autorizado por su empleador o compañía de seguros y que se realizará dentro de 180 días a partir de la fecha efectiva de la MPN o la fecha de la terminación del contrato entre la MPN y su médico.

Usted puede no estar de acuerdo con la decisión de su empleador sobre transferir su cuidado a la MPN. Si no quiere ser transferido a la MPN, pídale a su médico que lo está atendiendo por un informe médico que indique si tiene una de las cuatro condiciones indicadas arriba para poder posponer su transferencia a la MPN.

El médico que lo está atendiendo tiene 20 días a partir de la fecha de su petición para darle una copia del informe sobre su condición. Si el médico que lo está atendiendo no le da el informe dentro de los 20 días a partir de la fecha de su petición, el empleador podrá transferir su cuidado

permitido tener una segunda o tercera opinión sobre el disputado diagnóstico o tratamiento recomendado por el médico que lo está

a la MPN y estará obligado a utilizar un médico de la MPN.

Tendrá que darle una copia del informe a su empleador si desea posponer la transferencia de su cuidado. Si usted o su empleador no está de acuerdo con el informe de su médico sobre su condición, usted o su empleador puede disputarlo. Vea el plan de Transferencia de Cuidado para más detalles sobre el proceso de resolución de disputa.

Para una copia del plan entero sobre la Transferencia de Cuidado, en inglés o español, pregúntele a su contacto de la MPN.

▪ ¿Qué tal si estoy bajo tratamiento con un médico de la MPN que decide dejar la MPN?

Su empleador o compañía de seguros tiene un plan escrito para "La Continuidad de Cuidado" que determinará si es que podrá continuar temporalmente su tratamiento por su lesión de trabajo actual con su médico si su médico ya no está participando en la MPN.

Si su empleador decide que usted no califica para continuar su tratamiento con el médico que no es un proveedor dentro de la MPN, usted y el médico que lo está atendiendo deberán recibir una carta notificándole de esta decisión.

Si usted llena ciertos requisitos, tal vez podrá calificar para continuar su tratamiento con este médico hasta por un año antes de que tenga que elegir a un médico de la MPN. Estos requisitos están expuestos, "¿Puedo Continuar Ser Tratado Por Mi Médico?" en la caja descrita arriba.

Usted puede no estar de acuerdo con la decisión de su empleador sobre negarle la Continuidad de Cuidado con el proveedor que ya no es parte de la MPN. Si quiere continuar su tratamiento con este médico, pídale al médico que lo está atendiendo por un informe que indique si tiene una de las cuatro condiciones descritas en la caja de arriba para ver si califica para seguir recibiendo tratamiento de su médico actual.

El médico que lo está atendiendo tiene 20 días a partir de la fecha de su petición para darle una copia del informe sobre su condición. Si el médico que lo está atendiendo no le da el informe dentro de los 20 días a partir de la fecha de su

atendiendo.

petición, la decisión de su empleador de negarle la Continuidad de Cuidado con su doctor quien ya no participa en la MPN aplicará, y usted será requerido a escoger un médico de la MPN.

Tendrá que darle una copia del informe a su empleador si desea posponer la selección de un tratamiento con un médico de la MPN. Si usted o su empleador no está de acuerdo con el informe de su médico sobre su condición, usted o su empleador puede disputarlo. Vea el plan de transferencia de cuidado para más detalles sobre el proceso de resolución de disputa.

Para una copia del plan de la Continuidad de Cuidado, en inglés o español, pregúntele a su Contacto de la MPN.

▪ ¿Qué tal si tengo preguntas o necesito ayuda?

El Contacto de la MPN: Usted siempre puede ponerse en contacto con el Contacto de la MPN si tiene preguntas sobre el uso de la MPN y como mandar sus reclamos respecto a la MPN.

Asistente de Acceso Médico: Puede contactar el Asistente de Acceso Médico si necesita ayuda para encontrar médicos del MPN y la programación y confirmar citas.

La División de Compensación de Trabajadores (DWC): Si tiene algún interés queja, pregunta sobre la MPN, el proceso de notificación, o su tratamiento médico después de una lesión o enfermedad de trabajo, puede llamar a la Oficina de Información y Asistencia de la DWC al 1-800-736-7401. También puede consultar con la página web de la DWC en el www.dir.ca.gov/dwc y bajo el encabezado haga "Workers compensation programs and units" clic en "la red de proveedores médicos" para más información sobre las MPNs.

MPN Revisión Médica Independiente: Si usted tiene preguntas sobre el MPN, proceso de la MPN Revisión Médica Independiente póngase en contacto con la Unidad Médica de la División de Compensación de Trabajadores en:

DWC Medical Unit
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900.