

Power Equipment Maintenance, Inc.

Proven Performance / Quality Driven

EQUAL OPPORTUNITY EMPLOYER

110 Prosperity Blvd. Piedmont, SC 29673

PH: (888) 715-3914 FAX: (864) 375-0092

2010 PEM Employment Package

Please complete the attached paperwork and return to PEM via US Mail, Fed-Ex, or fax regardless of your last period of employment with PEM by date noted on the bottom of this form. ***We require a complete new employment package on each employee for the first work assignment each year at a minimum to ensure we have all the latest and current information on each of our employees.*** If at any time your information contained in these forms change it is your responsibility to notify our office of those changes.

Package Instructions:

- Complete the enclosed Employment Packet ***including making copies of the supporting documents required for completion of the I-9 form, i.e. Drivers license, social security card, birth certificate, state issued ID card, etc.***
- PEM STRONGLY encourages all employees to participate in our Direct Deposit program:
 1. **Effective February 2, 2009 ALL CHECKS/CHECK STUBS WILL BE SENT TO JOB SITE UNTIL COMPLETION OF JOB.**
 2. TRAVEL/LIVING CAN BE DEPOSITED INTO A CHECKING ACCOUNT OR SAVINGS ACCOUNT.
 3. With our Direct Deposit program you **MUST** include a voided check for each specific account along with completing the enclosed enrollment form(s).
- Also enclosed is PEM's Safety Handbook. Please read the handbook, then sign and return **ONLY** the back page.

Complete this package of information in its entirety and return ASAP, Not later than: _____

If you have any questions, please contact your recruiter as soon as possible at 888-715-3914 (toll free) or 864-375-9030.

Sincerely,

PEM Operations Department

Recruiter: _____ OPS Manager: _____

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PRE-EMPLOYMENT QUESTIONNAIRE
 EQUAL OPPORTUNITY EMPLOYER
EMPLOYEE INFORMATION

Full name as it appears on SS card:			
Social Security Number:		Date of Birth:	T-Shirt Size:
Mailing Address:		City	State
Physical Address:		City	State
Home Phone:	Mobile Phone:	Referred by:	
Email Address:			

In case of an Emergency Contact:	
_____	_____
_____	_____
_____	_____

References			
Name	Address & Phone	Occupation	Yrs Known

Payroll Check and Travel / Living (Per-Diem)
ALL CHECKS/CHECK STUBS WILL BE SENT TO JOB SITE UNTIL COMPLETION OF JOB ALL employees will be strongly encouraged to participate in our Direct Deposit program.

Do you reside in a city/town/county/school district, municipality, parish or other government entity, etc. that levies an **Income Withholding Tax, Disability Income Tax, or any other Payroll Withholding Tax?**

Yes No

If Yes, please provide the name of the county/city, etc. _____

Please provide a phone number for the Income Tax Withholding service in your area. _____

 All information contained in this application is true and correct to the best of my knowledge and belief. I understand that misrepresentations or omissions of any kind may result in denial of employment or be cause for subsequent dismissal if I am hired. I authorize the company to investigate my responses to this application and contact any or all of my former employers or individuals familiar with me or my employment background for the purpose of verifying any information I have provided and/or for the purpose of obtaining any information, whether favorable or unfavorable about me or my employment. I voluntarily and knowingly fully release and hold harmless any person or organization that provides information pertaining to me or my employment. I understand that upon receiving a job offer, a physical examination and drug screening may be required. (Note: If this a job requirement, you will be notified.) Regardless of whether I become employed by the company, I recognize that this application is not and should not be considered a contract of employment. I understand that employment at the company is on an at-will basis and that my employment may be terminated with or without cause and without notice at any time, at my option or the Company's, unless specifically provided otherwise in a written employment contract. I further understand that no company employee or representative has the authority to enter into a contract regarding duration or terms and conditions of employment other than an officer or official of the company and then only by means of a signed written document.

 Submitted by Applicant

 Date

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Employee PAYROLL CHECK Direct Deposit Enrollment Form

Payroll Manager—Please complete this section and enter data into your ADP Payroll system for employee enrollment. Then contact your CSR or AE for further instructions on how to update your employee's direct deposit information to ADP. NOTE: YOUR COMPANY NAME MUST BE FILLED IN BEFORE DISTRIBUTING THIS FORM TO YOUR EMPLOYEE FOR COMPLETION. (Please print.)

Company Code: **B7U** Company Name: **Power Equipment Maintenance, Inc.** Employee File Number: _____
Payroll Mgr. Name: _____ Payroll Mgr. Signature: _____

To enroll in Full Service Direct Deposit, simply fill out this form and give it to your payroll manager. **Attach a voided check for each checking account – not a deposit slip.** If depositing to a savings account, ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you are paid correctly.

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.

Memo: _____
⑆012345678⑆ 123456789 ⑆⑆ 0101

Routing/Transit
(A 9-digit number always
between these two marks)

Checking Account #

Check #
(This number matches the number in the upper
right corner of the check – not needed for
sign-up)

Important! Please read and sign before completing and submitting.

I hereby authorize Employer, either directly or through its payroll service provider, to deposit any amounts owed me, by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Employer, either directly or through its payroll service provider, to my account. In the event that Employer deposits funds erroneously into my account, I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Employer and Bank have received written notice from me of its termination in such time and in such manner as to afford Employer and Bank reasonable opportunity to act on it.

Employee Name: _____ Social Security #: _____ - _____ - _____

Employee Signature: _____ Date: _____

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.

Make sure to indicate the type of account, along with amount to be deposited, if less than your total net paycheck.

1. Bank Name/City/State: _____

BANK ROUTING AND ACCOUNT NUMBER WILL BE ENTERED PER YOUR ATTACHED VOIDED CHECK.

Checking Savings Other I wish to deposit: \$ _____ . ____ or Entire Net Amount

2. Bank Name/City/State: _____

BANK ROUTING AND ACCOUNT NUMBER WILL BE ENTERED PER YOUR ATTACHED VOIDED CHECK.

Checking Savings Other I wish to deposit: \$ _____ . ____ or Entire Net Amount

3. Bank Name/City/State: _____

BANK ROUTING AND ACCOUNT NUMBER WILL BE ENTERED PER YOUR ATTACHED VOIDED CHECK.

Checking Savings Other I wish to deposit: \$ _____ . ____ or Entire Net Amount

ATTENTION PAYROLL MANAGER:

Employers must keep each original employee enrollment form on file as long as the employee is using FSDD, and for two years thereafter.

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Employee TRAVEL/LIVING Direct Deposit Enrollment Form

*****Power Equipment Maintenance, Inc. does not offer direct deposit into a savings account for travel money and Per Diem at this time. The account must be a checking account.******

Complete this form if you want your Travel / Living reimbursements deposited to your private checking account. Please be advised that the information given MUST be correct in order for your reimbursements to be deposited into your account. We strongly recommend that you contact your bank to verify the information requested below.

To enroll in Travel/Living Direct Deposit, simply fill out this form return it to Power Equipment Maintenance Co, Inc. Attach a voided check for your checking account – not a deposit slip. Contact your bank to verify the Routing/Transit Number and Account number. It isn't always the same as the number on your check. This will help ensure that you are paid correctly.

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.

Memo: _____
⑆012345678⑆ 123456789 ⑆⑆

Routing/Transit
(A 9-digit number always
between these two marks)

Checking Account #

Important! Please read and sign before completing and submitting. This form will not be honored unless completed and signed.

I hereby authorize Power Equipment Maintenance Co., Inc. (hereinafter "Employer") to deposit any amounts owed me, by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Employer to my account. In the event that Employer deposits funds erroneously into my account, I authorize Employer to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Employer and Bank have received written notice from me of its termination in such time and in such manner as to afford Employer and Bank reasonable opportunity to act on it.

Check here if you elect to have your travel / living deposited in the same checking account as your payroll check. You still have to include a copy of your voided check and both direct deposit enrollment forms, and you are still required to complete the following authorization section.

Employee Name: _____ Social Security #: _____ - _____ - _____

Employee Signature: _____ Date: _____

Account Information

Bank Name/City/State: _____

Routing/Transit #: _____ Account Number: _____

Checking

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PRE-EMPLOYMENT QUESTIONNAIRE

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CONFIDENTIAL HEALTH HISTORY

Name (Last, First Middle)				Social Security Number		
Age	Sex	Birth date	Family physician	Physician's Address		
Please answer the following questions to the best of your knowledge.					YES	NO
1.	Have you been under the care of a doctor or clinic for the last six (6) months?					
2.	Have you ever had any operations, serious illness, or injuries?					
3.	Have you ever been hospitalized?					
4.	Have you a chronic or recurring ear infection?					
5.	Have you any trouble hearing or have any ringing in your ears?					
6.	Do you wear a hearing aid?					
7.	Do you have any eye problem that is not corrected by glasses or contact lenses?					
8.	Do you have frequent headaches?					
9.	Do you have glaucoma?					
10.	Have you ever had a tetanus toxoid injection?					
11.	Have you had a chronic cough, shortness of breath, or ever coughed blood?					
12.	Have you had asthma, hay fever, tuberculosis, or chronic bronchitis?					
13.	Have you had heart trouble, high blood pressure, or rheumatic fever?					
14.	Have you ever had chest pain or an irregular heart beat?					
15.	Have you had stomach or intestinal trouble, sever abdominal pain or ulcers?					
16.	Have you ever had liver problems, colitis, hemorrhoids, or rectal bleeding?					
17.	Have you ever been treated for kidney or bladder trouble or had kidney stones?					
18.	Have you ever had anemia, diseases of the blood, phlebitis, varicose veins, or swelling of the ankles?					
19.	Have you ever been told you had diabetes?					
20.	Have you ever had any seizures, disorders of the nervous system, or epilepsy?					
21.	Have you ever fainted or had paralysis or dizzy spells?					
22.	Have you lost consciousness in the last five (5) years?					
23.	Have you ever been clinically diagnosed for nervous exhaustion, depression, or mental breakdown?					
24.	Have you ever seriously considered suicide?					
25.	Have you been rejected for employment, military service, or life insurance for health reasons?					
26.	Do you have joint pain or arthritis?					
27.	Have you ever had any problems with your back, neck, knees, arms, shoulders, or joints?					
28.	Have you any condition that will require surgery in the future?					
29.	Are you now taking pills, injections, or medicines for any reason?					
30.	Do you have allergies (medicines, food, other)?					
31.	Do you have any recurring skin conditions (Dermatitis) or rash?					
32.	Have you any health problems not previously mentioned?					
33.	Have you ever been clinically diagnosed for drug use?					
34.	Have you ever had an on-the-job injury that resulted in a workman's compensation claim?					
35.	Have you ever been occupationally exposed to asbestos, silica, or other dusts?					
36.	Do you presently smoke?	Yes	No	How much?	What?	
	Have you ever smoked?	Yes	No	How much?	What?	
37.	Do you use alcohol beverages?	Yes	No			
38.	How may cups of coffee do you consume per day?					
Explain any "YES" answers to questions 1 through 35.						

I understand that this information will be kept confidential and it shall only be used to determine my physical qualifications for proper job placement. I agree to have a physical examination and am aware that false statements may be sufficient cause to disqualify me for employment, or, if employed, realize that any evidence of falsification of information will be considered adequate cause for discharge.

Signature

Date

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NOTICE OF INJURY EMPLOYEE INFORMATION

Notice of Injury – Employee Requirements

- Report the injury to the Power Equipment Maintenance, Inc. (PEM) site contact, customer and PEM home office immediately. (888) 715-3914
- Assist site contact or supervisor in completing the Accident Investigation Form and First Report of Injury within 24 hours of injury.
- Contact the workers compensation advisor at PEM home office for assistance.

Notice to Employee

- First Aid treatment will be provided for you on site. Initial treatment beyond First Aid must be handled in the following manner:
 - Emergency Treatment – Employee, with assistance of site contact or supervisor will go to the closest hospital emergency room if warranted.
 - All non-emergency medical treatment, evaluation and referrals are to be arranged by site contact or supervisor if still on site, if supervisor is no longer on site then it should be arranged by PEM home office.
 - If medical treatment is not apparent at the time of initial injury but becomes necessary at a later date or is a follow up medical treatment you must contact the workers compensation advisor at PEM home office to arrange medical treatment.
 - If an employee desires to obtain medical treatment other than that provided by PEM they have the right to ask, one time only to approve a change to another physician.
 - Medical treatment will not be provided or approved unless the injury was initially reported following the policy under “Notice of Injury” as shown above.
- Any loss of work time related to an on the job injury requires written medical authorization. The employee’s site contact or supervisor and the workers compensation advisor at Power Equipment Maintenance, Inc. headquarters must be informed immediately and provided with written medical authorization that the time loss is due to a job-related injury.

I _____, acknowledge receipt of a copy of this notice.

_____/_____
Employee Signature / **Date**

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Authorization and Agreement Notice

for

Pre-Employment, Reasonable Suspicion, Post Incidence and Random Drug and Alcohol Testing

I understand and agree in the interest of the safety of my fellow workers, myself, the general public, and the intent of Power Equipment Maintenance, Inc. to provide a work environment free of the influence of controlled substances. My initial and continued employment is dependent upon my compliance with terms and conditions of the Power Equipment Maintenance, Inc. Policies and Procedures relative to drugs, alcoholic beverages, and weapons.

Acceptance of employment with Power Equipment Maintenance, Inc. implies my consent to submit to examination upon demand for the presence of controlled substances/alcohol in my belongings, on my person, or in my body. I further authorize the collecting agency of such specimens or examination and/or laboratory to provide Power Equipment Maintenance, Inc. with specimen test results for any and all urine, blood or sputum specimens. I understand that my employment will be terminated with Power Equipment Maintenance, Inc. if I refuse to cooperate and/or if the test results of a specimen confirms presence of a controlled substance or substances and/or alcohol.

I agree to hold the Company, its agents, directors, officers, and employees harmless from any and all liability in connection with the testing for controlled substances and/or alcohol, and any other actions conducted by the Company relative to the administration of the drug, alcoholic beverages, and weapons policy.

Confidentiality

The confidentiality of any information received by PEM, Inc. through a substance abuse testing program shall be maintained, except as otherwise provided by law.

Opportunity to Contest or Explain Test Results

Employees and job applicants who have a positive confirmed test result may explain or contest the result to PEM, Inc. within five (5) working days after PEM, Inc. contacts the employee or job applicant and shows him/her the positive test result as it was received from the laboratory in writing.

Active Employee Certificate of Agreement

I do hereby certify that I have received and read the PEM, Inc. Substance Abuse and Testing Policy and have had the Drug-Free Workplace program explained to me. I understand that if my performance indicates it is necessary, or in the case of random testing, I will submit to a substance abuse test. I also understand that failure to comply with a substance abuse test request, or a positive result may lead to termination of employment and denial of unemployment benefits. I understand that failure to submit to a substance abuse test, or a positive test result may affect my right to obtain workers' compensation benefits, I further agree to and hereby authorize the release of the results of said tests to PEM, Inc. Nothing in this consent form is to be construed as a contract between the parties.

Applicants Name: _____ Date: _____
(Please Print)

Applicants Signature: _____