**American Pool**

The leader in the swimming pool industry

Job Description

Job Title:

**Lifeguard**



1I SUMMARY OF FUNCTIONS:

As a lifeguard you are responsible for ensuring the safety of facility patrons by preventing and responding to emergencies appropriately.

2 I MAJOR DUTIES AND RESPONSIBILITIES:

- Recognize and response effectively in emergencies.

- Enforce all pool policies,rules,and regulations.

- Inspect the facility on a daily schedule and report any unsafe conditions or equipment to your supervisor.

- Complete all chemical log readings every hour that you are working.

- Participate in regular in-se!Vice training sessions. (If applicable)

-Complete additional duties as assigned by your supervisor.

-Maintain the cleanliness of pool- including but not limited to: Vacuuming, brushing,skimming, and cleaning the tiles of the pool.

- View and confirm Alsl cheduled shifts online.

- Make sure to request any days off AT LEAST TWO WEEKS in advance. It is solely YOUR responsibility to make sure all requested days off are cleared from your schedule.

-Reporting any and all inclement weather to your supervisor as soon as possible.

-Be in uniform at all times when on guard duty. The uniform consists of a guard T-shirt with either a guard suit or a plain red bathing suit. (Bikinis are not permitted.)

3 I REQUIREMENTS:

-American Red Cross Lifeguard Training and First Aid/CPR/AED

-Complete online OSHA Webinar {video)

-Attend lifeguard orientation

Print Name: Date:--- ---- ----- - -- -

Employee Signature: \_ \_ Parent Signature {If under 18): \_ Employer Representative Signature: Date:----- -- - --- - - ----

Disclaimer

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not to be construed as an exhaustive list of all responsibilities, duties,and skills required of personnelso classified. All personnelmay be required to perform duties outside of their normal responsibilities from time to time, as needed.

**POOL PREFERENCE FOR 2015**

.... \ llJ

fQ} **GliA.RB. fOflliFE**

Pool Choices are offered to returning guards first, but then we will be assigning on a first come, first serve

basis! Please fill out and return this form to secure your pool of choice for next summer. *(We will do our best to accommodate everyone's top pool choices, but please be advised that this is not always possible due to certain circumstances).*

If you are under 18 yrs of age BEFORE your first day of work, it is MANDATORY State Law to submit working papers. You will NOT be scheduled until they are completed and turned into the office.

NAME:

STREET: CITY: STATE: ZIP: PHONE: CELL: EMAIL:

*\*Please include your email address. It is mandatory for the online scheduling system. MAKE SURE YOU ARE CHECKING YOUR EMAIL FOR RE-HIRE and other important information/*

EMERGENCY CONTACT: PHONE:

Desired Pay: Approximate Start Date: End Date: Desired Area: Approximate Hrs. Wanted Per Week:

POOL WISH LIST

1.

2.

3.

NEED TO BE TRAINED/RE-CERTIFIED IN: CPR. \_ LG \_ BOTH \_\_\_

Want extra ca$h? REFER YOUR FRIENDS!! We offer hours that can accommodate any schedule!

*\*Certain stipulations must be met.*

Check your certifications to make sure that they are VALID through September 1, 2015 if not call the office about class information or contact your local Red Cross.

Check out our Training Site: training.guardforlife.com.

SIGN: DATE:

*RMS*

Mailing Address: RMS- PO Box 435, Berlin NJ 08009- Phone: 856.767.5159- Fax: 856.767.8303

AVAILABILITY EVALUATION



Name: Date:

Please fill out your summer availability on this form to the best of your knowledge. This will help us create a summer schedule that works for everyone. It is in your best interest to complete this form as accurately as possible in order to prevent any future problems.

What is your last day of school? , When are you available to start working? *1 1*

When do you return to schooi? . . What is your projected last day of work? -'------'---

Will you be available weekends while school is in session? o Yes 0 No

If no, please explain:----------------------------------------

Will you be available weekday afternoons when school is in session? 0 Yes 0 No

If no, please explain:---- --------- - --------------------------

Will you be available to work MemorialDay Weekend? o Yes 0 No Labor Day Weekend? 0 Yes 0 No

If no, please explain:---------------------------------------- Please list any vacations, specific days you need off or expected summer class schedules:------------ -

Please list any other schedule conflicts that we need to know about:----------- -----------

Overall Weekly Availability

Please write "OPEN" In any square that you are available to work and put an X in any square where you are unable to work.

*Please note that weekend availability is* a *requirement for many of our pools.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | SUN | MON | TUE | WED | THU | FRI | SAT |
| MORNING |  |  |  |  |  |  |  |
| EVENING |  |  |  |  |  |  |  |

Signature:

Entered Date: Staffing Department:

\_\_

A.aiON PCX::t. Cop

-.:

yright© American Pool Enterprises, Inc.All rights reserved. Guard for Life is an American Pool lifeguard program. LG012014

**New Health Insurance Marketplace Coverage**

• **Options and Your Health Coverage**

Form Approved

OMB No. 1210-0149

(expires 1 -31-2017)

**PART A: General Information**

When key par ts of the health care law take effect in 2014, there will be a new way to buy health insurance: t he Health Insurance Marketplace. To assis t you as you evaluate options for you and your family, this notice provides some basic inf ormation about the new Marketplace and employment - based health coverage o ff er ed by your employer.

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget . The

Marke t place offer s "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax cr edit that lowers your monthly premium righ t away. Open enrollment for heallh insurance

coverage thr ough the Market place begins in October 201 3 for coverage starting as early as January 1 , 2014.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**

You may qualif y to save money and lower your monthly premium , but only if your employer does not offer coverage, or of f ers coverage that doesn't m eet certain standards. The savings on your pr emium that you'r e eligible f or depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an off er o f health coverage from your employer that meets cer tain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer ' s health plan. However, you may be eligible for a tax credit t1at lower s your monthly pr emium. or a r eduction in c ertain cost-sharing i f your employer does not offer coverage t o you at all or does not offer coverage t hat meets cer tain s tandards . If the cost of a plan from your employer that would cover you (and not any other member s of your fam ily) is more than 9.5% o f your household income f or the year, or if the coverage your employer provides does not meet the "minimum value" standar d set by the

Af f ordable Care Act . you may be eligible for a tax credit. 1

Note: If you purchase a health plan thr ough the Marketplace instead o f accepting health coverage of f ered by your employer, t hen you may lose the employer contribution (if any) to t he employer-offered coverage. Also. this employer contribution -as well as your employee contribut ion to employer-offered coverage- is o f ten excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marke tplace are made on an after­ tax basis.

**How Can I Get More Information?**

For more information about your cover age o f fered by your employer , please check your summary plan description or contact

The Mar ketplace can help yo u evaluate your coverage options, including your eligibility f or coverage t hr ough t he Marketplace and its cost. Please visit HealthCare.gov for more inf ormation, including an online application f or health msurance coverage and contact informat1on for a Health Insurance Marketplace in your area.

1 An employer -sponsored health plan meets the "m1n1m urn value standard" •I Ihe plan's share of the total allowed benefit costs covered

by the plan IS no less than 60 percent of such costs.

**PART B: Information About Health Coverage Offered by Your Employer** This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name

American Pool Enterprises

5. Employer address

11515 Cronridge Drive, Suite Q

4. Employer Identification Number (EIN)

52-2007104

6. Employer phone number

443-471-1190

7. City

Ownings Mills

10. Who can we contact about employee health coverage at this job?

Kristine Kimbrel

8. State

MD

9. ZIP code

21117

11. Phone number (if different from above)

443-471-1190

12. Email address

[kkimbrel@americanpool.com](mailto:kkimbrel@americanpool.com)

Here is some basic information about health coverage of f ered by this employer :

•As your employer, we offer a health plan to:

0 All employees. Eligible employees are:

Some employees. Eligible employees are:

Active employees working 30 or more hours per week

•With respect to dependents:

We do o f fer coverage. Eligible dependents are·

Dependents to age 26 and spouse

0 We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this cover age to you is intended to be affordable, based on employee wages.

.... Even if your employer intends your coverage to be affordable. you may still be eligible for a premium

discount through the Marketplace. The Marketplace will use your household incom e, along with other factors, to determtne whether you may be eligible f or a premium discount. If, for example. your wages vary from

week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage tn the Marketplace, HealthCare.oov will guide you through t he process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

EMPLOYEE DIRECT DEPOSIT ENROLLMENT FORM

AMERICAN POOL ENTERPRISES INC. and its FAMILY OF COMPANIES

To enroll in the direct deposit program of American Pool Enterprises, Inc. ("Employer"), please fill out and sign this form, attach a voided check for your checking account, and give the form and voided check (and NOT a deposit slip) to Employer's payroll department. If the deposit will be made to a savings account, you need to ask your bank to give you the appropriate routing/transit number for your account, as it is not always the same as the number on a saving deposit slip.

PLEASE READ & COMPLETE THIS FORM BEFORE SIGNING & SUBMITTING TO EMPLOYER

I hereby authorize Employer to deposit any amounts owed me, as instructed by Employer, my employer, by initiating credit entries to my account at the financial institution (hereinafter the "Bank") indicated on this form. 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 authori zation 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 maooer as to afford Employer and Bank reasonable opportunity to act on it.

Em ployee Name:

Employee Signature: - - - --- - --------------

Date:

Employee Account Information:

1. Bank Name:

Routing/Transit#:

Jtccount Number: - ----------

I wish to deposit: $ per pay, or\_ entire net amount of pay

Please check type of account: Checking Savings Other

2. Bank Name: --------------------- -

Routing/Transi t#: --- -- ----- Account Number: ----------

I wish to deposit: $--- per pay, or \_ entire net amount of pay

Please check type of account: \_ Checking \_ Savings Other

3. Bank Name: --- ----- --------------

Routing/Transit #: \_ Account Number: ----------

I wish to deposit: $ \_ per pay, or \_entire net amount of pay

Please check type of account: \_Checking \_ Savings Other

**COMDATA**

**Pavme!'!t lno :Jhon**

**Exhibit A:28**

**PAYROLL CARD ENROLLMENT AND CONSENT FORM**

Please complete the following and refer to the second page for associated fees and information.

**PRINT NAME**

(First) (Middle) (Last)

**HOME ADDRESS**

**CITY COUNTY** ----------------------- **STATE ZIP** ----------------------- **HOME PHONE EMPLOYEE NUMBER** ----------------------- **WORK LOCATION** ---- - -- -----------

BY SIGNING BELOW,ICONSENT TO RECEIVE MY WAGES BY ELECTRONIC TRANSFER TO MY CERIDIAN PAYROLL CARD.

I ACKNOWLEDGE THAT MY EMPLOYER HAS PROVIDED ME A COPY OF THE CARDHOLDER AGREEMENT AND THE SCHEDULE OF THE FEES I WILL INCUR USING MY PAYROLL CARD. I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE TERMS IN THE CARDHOLDER AGREEMENT AND FEES THAT I WILL INCUR USING MY PAYROLL CARD.

**EMPLOYEE SIGNATURE DATE**

*Parent/Legal Guardian Signature (if employee is under 18) Date* -------------

If you have received an Instant Issue Card, enter its 16-digit Card Number below:

*\_ 1\_1\_1\_ 1\_ 1\_ 1\_ 1\_ 1\_ 1\_ 1\_ 1\_ 1\_ 1\_ 1\_ 1\_/*

***Number MUST be completed before submitting to Payroll.***

Your Activation Code will be your Date of Birth in this format: IIIII I I I I

Page **1**of 2 Rev 01· 28-13\_DRAFT02

**6-ZDIAN**

**PAYROLL CARD SCHEDULE OF FEES**

The fees listed below will be deducted from your Payroll Card balance for each transaction after your first transaction each payday.

There is no fee for the first transaction made after pay has been loaded to your Payroll Card.

|  |  |
| --- | --- |
| 1-llffiiJir.lrt.- fi' :£ t} J.:r5£-: - ·!'; \_;,rl':.y! •--!lD" L | |
| Customer Service (Bilingual, 2417) | |
| Via Web  IVR  Live Operator | $0.00 |
| $0.00 |
| $0.00 |
|  | |
| Transactions Domestic or International | |
| First Transaction after each Load, regardless of Transaction Type | $0.00 |
| Point of Sale Transactions: Signature-Based  Purchases, Refunds, Declines  Point of Sale Transactions: PIN-Based  Purchases, Refunds, Declines, Cashback with Purchase | $0.00  $0.00 |
| ATM Transactions  ATM Withdrawal  ATM Balance Inquiry, and/or Decline | $1.75  $1.25 |
| Bank Teller Withdrawal (at participating banks where MasterCard is accej:lled) | $5.00 |
|  | |
| Other | |
| Text Message Alerts (charges specific to moblie carriers may apply) | $0.00 |
| Expired Card Replacement | $0.00 |
| Lost Card Replacement (One free per year) | $5.00 |
| Companion Card (per request) | $5.00 |
| Card-to-Bank Transfer, Automatic | $1.00 |
| Card-to-Bank Transfer,Manual | $1.50 |
| Cross-Border Currency Fee (InternationalTransactions) | 1% |
| Comchek Draft | $3.00 |
| Claim Research- Invalid Claims | $50.00 |

Your Payroll Card charges no fees for the following\_;\_

Monthly Fees Dormancy Fees Overdraft Fees Minimum Balance Fees

Live Customer Service, VRU or Web

Access Fees

Point of Sale Purchases

Text Message Alerts

FREE Text Message

For the easei st way to manage your Payroll Card, sign up to receive text message alerts to your mobile phone.Getting your transaction and balance information has never been easier! You can sign up one of two ways:

Sign up online at [www.cardholder.comdata.](http://www.cardholder.comdata/) com and select Bankingffext Messaging from the drop-down menu, QL:

Sign up via phone by calling 888-265-8228 and following the prompts for setting up text message alerts

Please read below for other helpfulinformation.



You will be notified of any changes in these fees. You will not earn interest on your funds.

ATM owners outside of the Allpointn.t surcharge free ATM network, and other places where you use your Payroll Card, may charge fees that will be deducted from your Payroll Card balance.

• If you use your Payroll Card outside the US, or if you make a purchase in a currency other than US Dollars:

The amount deducted frorn your funds will be converted into US Dollars by the card network. The card network will charge a cross-border fee of .80% and currency conversion fee of .20% (for a total fee of 1% of the transaction amount) to be included in the transaction amount. This card network cross border and currency conversion charge is independent of and in addition to any international fee indicated in the Schedule of Fees above.

1 Your carrier's message and data rates may apply.

Page 2 of 2 Rev 01·28 13\_DRAFT02

**OSHA HAZARD COMMUNICATION EMPLOYEE INFORMATION**

As an employee of APM, LLC. d/b/a American Pool, hereinafter referred to as "Company•, you will not be expected to handle any hazardous chemicals. However, it is important that you read the information contained herein so that you are aware of OSHA's Hazard Communication Standard and some important points about the hazardous chemicals that might be present at your worksite.

Overview Of OSHA Hazard Communication Standard- The purpose of this OSHA regulation is to ensure that information concerning the hazards of all chemicals in the workplace is transmitted to employees. Company transmits this information to its employees in accordance with OSHA's requirements by means of container warning labels, safety data sheets (SDS) and the training of employees who actually handle the hazardous chemicals.

Product Labels- All containers of hazardous chemicals are labeled with the identification of the chemical and appropriate warnings from the manufacturer. Do not remove or deface any labels or warnings on a chemical container. If you observe any unlabeled or unmarked containers, contact your immediate Supervisor through the Company Office.

SDS - SDS sheets for all hazardous materials are kept in the 3 ring Management binder at each facility under our management. A

copy of all SDS is also kept at our office. The product name for each SDS will coincide with the name found on the chemical label.

Emergencies - In the event of a suspected leak or other hazardous chemical problem, immediately clear the area and contact your immediate Supervisor through the Company Office.

Hazardous Chemical Handling- Individuals who have not received and acknowledged in writing completion of Company's Hazard

Communication Training for Chemical Handling shall not handle any hazardous chemical on the job.

*I verify that I have read and understand the OSHA Hazard Communication information above.*

Employee Name. Employee Signature .Date \_

*Hepatitis B Vaccine Declination*

I understand that due to my occupational exposure to blood or other potentially infectious materials Imay be at risk of acquiring Hepatitis B virus (HBV) infection. Ihave been given the opportunity to be vaccinated with Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.If in the future I

continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B

vaccination series at no charge to me.

|  |  |
| --- | --- |
|  | to |
| Employees Name (PRINT) | Employee Signature |

|  |  |
| --- | --- |
|  |  |
| Date | IF UNDER 18, REQUIRES PARENT SIGNITURE |

*Personal Protective Equipment*

Ihave read and understand the Personal Protective Equipment Policies and procedures (www.guardforlife.com) and agree to abide by them. Iunderstand that any violation of the above policies is reason for disciplinary action up to and including termination.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employees Name (PRINT) | Employee Signature | Date |

*Bloodborne Pathogen Exposure*

I have read and understand the Bloodborne Pathogens Exposure Plan (www.quardforlife.com) and agree to abide by them. 1

understand that any violation of the above policies is reason for disciplinary action up to and including termination.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employees Name (PRINT) | Employee Signature | Date |

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has a fist of six physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is attached for you to view. Also, may get a copy of the

list on guardforlife.com.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306

(f.1)(1)(i)

MEDICAL TREATMENT:DURING THE FIRST 90 DAYS

(please initial each point below)

You have the RIGHT to receive reasonable If a listed provider prescribes surgery for you, and necessary medical treatment for your work injury you have the RIGHT to receive a second opinion from or occupational illness. Your employer must pay for any provider of your choice. If that opinion differs from the treatment, as long as the treatment is by one of the opinion of the listed provider, you have the RIGHT the listed providers. to choose which course of treatment to follow. If you

You have the RIGHT to choose which of the choose the treatment prescribed in the second listed providers will treat you for your work injury or opinion, you must receive the treatment from a listed illness. provider for a period of 90 days after the date of your

You have the RIGHT to switch among any of visit to the provider of the second opinion.

the listed providers when you receive treatment; if a You have the RIGHT to receive emergency listed provider refers you to provider not on your medical treatment from any provider. However, non- employer's list, you have the RIGHT to receive emergency treatment must be given by a listed treatment from a referral provider. provider.

If you seek treatment for your work injury or You have the Duty to visit one or more of the

illness from a provider who is not on the list, your listed providers for the first 90 days of treatment for employer may not have to pay for medical treatment your work injury or illness if you expect your employer during the 90 day period. Therefore, you should talk to pay for the medical treatment you receive.

to your employer before seeking treatment from a If you are injured at work or suffer an provider who is not on the list. occupational illness you will notify the Main Office at

215-283-0300 immediately. You will also need to

complete an incident report and have that given to the office detailing what happened.

IMPORTANT: The requirements your employer must meet to have a valid list of 6 providers are shown on the reverse side of this form. If the list does not meet the requirements, it is not valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician and other health

care provider.

\_\_ You have the DUTY to notify your employer if you have received treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this

notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties. If you have questions. be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT {check one):

time of hire

When I was injured Other

Print Name:

Date: \_

Employee signature: Parent Signature {if under 18): \_ Employer Representative: Date: \_

Panel

NOTICE TO E:MPLOYEES

Your employer bas provided for the payment of Benefits under the Workers' Compensation Act oftbis State by

CNA

IN CASE OF WORK-RELATED INJURY

• *lf* you suffer a work-related injury, your emp loyer or its insurance company must pay for reasonable surgical and medical services and supp lies, orthopedic ap pliances and prostheses, including training in their use.

• *ln* order to ensure that your medical treatment will be paid for by your employ er or the insurance company , you must immediately

advise your supervisor of your injury, and be treated by one of the licensed phys icians or practitioners of the healing art s listed below:

DESIGNATED PHYSICIANS

(including address, telephone nwnber, and area of medical specialty)

l. Original ProviderEdited Provider 2. Original ProviderEdited Provider 3. Original ProviderEdited

Edited Edited Provider

Parkwood Medical Practice PC Aland, Christopher M., MD Edited

*Family Practice* Reconstructive Orthopaedic Industrial Healthcare

12401 Academy Rd Ste 203 Associates IT, PC Center

Philadelphia, PA 19154 *Orthopedic Surgery Occupational Medicine*

215-637-3100 3300 Tillman Dr Fl2 *Clinic*

Bensalem, PA 1 9020 2804 S Hampton Rd

215-642-6900 Philadelphia, PA 19154

215-677-0930

4. Original ProviderEdited Provider 5. Original ProviderEdited Provider

Edited Edited

CareSTAT Urgent Care Centers Brady, James D., DC

-Abington James D Brady De

*Urgent Care* James D Brady DC

1468 Old York Rd *Chiropractic Care*

Abington, PA 19001 661 Bristol Pike

610-482-4949 Bensalem, PA 19020

215-245-1000, 215-245-5110

Employment Eligibility Verification



Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form 1-9

OMB No. 1615-0047

Expires 03/31 /201 6

II>START HERE. Read instructions carefully before completing this form.The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form 1-9 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 | | | Other Names Used *(if any)* | | | |
| Address *(Street Number and Name)* | Apt. Number | City or Town | | State | | Zip Code |
|  | E-mail Address | | | | Telephone Number | |
| 0 -[ ] -[ ] | | | | |

Date of Birth *(mmldd/yyyy)* IU.S. Social Security Number

Iam aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

Iattest,under penalty of perjury, that Iam (check one of the following):

D A citizen of the United States

D A noncitizen national of the United States *(See instructions)*

D A lawful permanent resident (Alien Registration Number/USCIS Number): \_

D An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) .Some aliens may write "N/A" in this field.

*(See instructions)*

*For aliens authorized to work , provide your Alien Registration Number/USC/S Number OR Form 1-94 Admission Number:*

1. Alien Registration Number/USCIS Number: \_

3-0 Barcode

OR Do Not Write in This Space

2. Form 1 -94 Admission Number:-----------------

If you obtained your admission number from CBP in connection with your arrival in the United

States, include the following:

Foreign Passport Number: ----------------------- Country of Issuance: --------------------- - -- -

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*

Signature of Employee: Date *(mmlddlywy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest,under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

I

Signature of Preparer or Translator: Date *(mm/dd/yyyy):*

Last Name *(Family Name)* First Name *(Given Name)*

Address *(Street Number and Name)* ICily or Town IState I Zip Code

*Employer Completes Ne.xt Page*

f orm 1-9 03/08/1 3 N Page 7 of9

**Section 2. Employer or Authorized Representative Review and Verification**

*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority,\_ document number, and expiration date, if any.)*

Employee Last Name, First Name and Middle Initial from Section 1:

List **A**

Identity and Employment Authorization

**OR** List **B**

Identity

**AND** List C

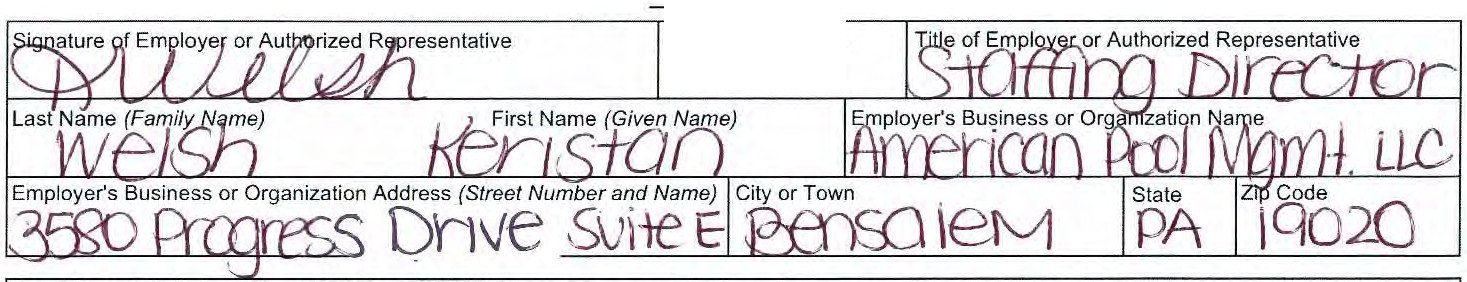
Employment Authorization

|  |  |  |  |
| --- | --- | --- | --- |
| Document Title: | Document Title:  Issuing Authority: Document Number:  Expiration Date *(if any)(mmldd!yyyy):* | Document Title: | |
| Issuing Authority: | Issuing Authority: | |
| Document Number: | Document Number: | |
| Expiration Date *(if any)(mmldd!yyyy):* | Expiration Date *(if any)(mmldd!yyyy):* | |
| Document Title: |  | | |
| Issuing Authority: |
| Document Number: |
| Expiration Date *(if any)(mm/dd!yyyy):* |
|  | | 3-D Barcode  Do Not Write in This Space |
| Document Title: |
| Issuing Authority: |
| Document Number: |
|  | | |
| Expiration Date *{if any)(mmldd!yyyy):* |

**Certification**

I attest, under penalty of perjury,that (1) Ihave examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mmldd/yyyy):* (See *instructions for exemptions.)*



Date *(mm!ddlyyyy)*

**Section 3. Reverification and Rehires** *(To be completed and signed by employer or authorized representative.)*

A. *N ew* Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Intiial B. Date of Rehire *(if applicable) (mmlddlyyyy):*

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title: Document Number: Expiration Date *(if any)(mm!dd/yyyy):*

I attest,under penalty of perjury, that to the best of my knowledge,this employee is authorized to work in the United States, and if the employee presented document(s),the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative: Date *(mmlddlyyyy):* Print Name of Employer or Authorized Representative:

**LISTS OF ACCEPTABLE DOCUMENTS All documents must be UNEXPIRED**

Employees may present one selection from List A

or a combination of one selection from List 8 and one selection from List C.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **LIST A LIST B LIST C**  **Documents that Establish Documents that Establish Documents that Establish**  **Both Identity and Identity Employment Authorization**  **Employment Authorization OR AND** | | | | |
| **1.** U.S. Passport or U.S. Passport Card |  | **1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | **1.** A Social Security Account Number card, unless the card includes one of the following restrictions:  (1) NOT VALID FOR EMPLOYMENT  (2} VALID FOR WORK ONLY WITH INS AUTHORIZATION  (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION |
| **2.** Permanent Resident Card or Alien  Registration Receipt Card (Form 1-551) |
| 3. Foreign passport that contains a temporary 1-551 stamp or temporary  1-551 printed notation on a machine- readable immigrant visa |
| **2.** | ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address  School ID card with a photograph |
| **4.** Employment Authorization Document that contains a photograph (Form  1-766) | 2. Certification of Birth Abroad issued by the Department of State (Form FS-545} |
| 3. |
| 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:  a. Foreign passport; and  **b.** Form 1-94 or Form I-94A that has the following:  (1) The same name as the passport;  and  (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or  limitations identified on the form. | 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| **4.** Voter's registration card | |
| 5. U.S. Military card or draft record | |
| **4.** Original or certified copy of birth certificate issued by a State. county, municipal authority, or territory of the United States bearing an official seal |
| **6.** Military dependent's ID card | |
| 7. U.S. Coast Guard Merchant Mariner  Card | |
| 8. Native American tribal document | | 5. Native American tribal document |
| **9.** Driver's license issued by a Canadian  government authority | | **6.** U.S. Citizen ID Card (Form 1-197) |
| **7.** Identification Card for Use of Resident Citizen in the United States (Form 1-179) |
| **For persons under age 18 who are unable to present a document listed above:** | |
| 8. Employment authorization document issued by the Department of Homeland Security |
| 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form  1-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI |
| **10.** School record or report card | |
| **11.** Clinic, doctor, or hospital record | |
| **12.** Day-care or nursery school record | |

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers {M-274).**

**Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.**

CLGS-32·6 (8·11)



**RESIDENCY CERTIFICATION FORM Local Earned Income Tax Withholding**

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

N..AME (Last Narne, FIrSI Narne, MIddlemI t1aI) STREET ADDRESS (No PO Box, RD or RR)

EMPLOYEE INFORMATION - RESIDENCE LOCATION

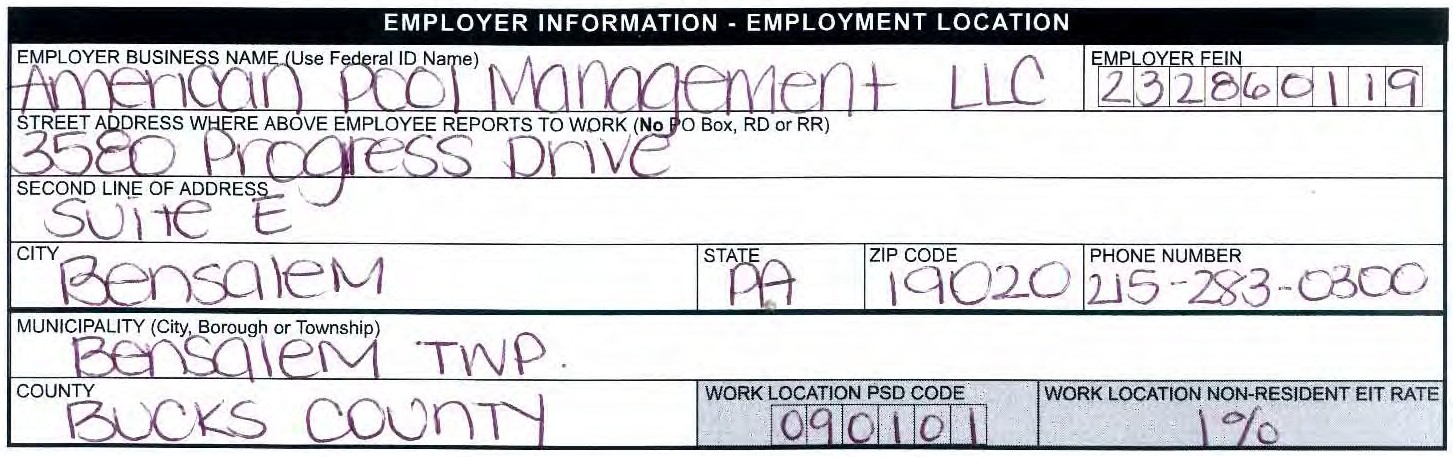
I I I I I

SECOND LINE OF ADDRESS

CITY ISTATE IZIP CODE IDAYTIME PHONE NUMBER MUNICIPALITY (City, Borough or Township)

COUNTY IRESIDENT PSD CODE ITOTAL RESIDENT EfT RATE

n111 I I



CERTIFICATION

Under penalties of pe ury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my {our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE IDATE (MM/DD/YYYY)

PHONE NUMBER IEMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EfT (Earned Income Tax) RATES,

please refer to the Pennsylvania Department of Community & Economic Development website:

[www.newPA.com](http://www.newPA.com/)

**Form W-4 (2015)**

The exceptions do not apply to supplemental wages Nonwage income.It you have a large amount of greater than S1,000,000. nonwage income,such as interest or dividends.

Basi c Instructions. If you are not exempt. complete consider making estimated tax payments using Fonm

Purpose.Complete Fomn W-4 so that your employer the PersonalAllowances Work sheet below.The 104Cf.ES,EsWnated Tax for Individuals.OtherWise,you

can v.ithhold the correct federal income tax from your worksheets on page 2 further adjust your may owe additional tax.If youhave pension or annuity pay. Consider completing a new form W-4 each year withholding allowances based on itemized income, see Pub.505 to f nd out if you should adjust

and when your personal or financial situation changes. deductions,certain credtis. adjustments to Income. yo or withholding on Fomn W-4 or W-4P.

Exemption from withhold ng.If you are exempt, or two-earners/multiple jobs situations. Two earners Ot" muUi ple jobs. tt you have a

*(1)* complete only l nes 1, 2,3, 4.and 7 and sign the form Complete all worksheets that apply.However,you working spouse or more than one job, figure the

°

0 to val idate it. Your exemption for 2015 expires may claim fewer (or zero) allowances. For regular total number of allowances you are entitled to claim February 16, 2016. See Pub.505. Tax Withholding wages, withholding muslbe based on allowances on all jobs using worksheets from only one Form and Estimated Tax. you claimed and may not be a fiat amount or W-4.Your withhOlding usually will be most accurate

l[) percentage of wages. when all allowances are claimed on the Form W-4

0 Note. IIanother person can claim you as a dependent for the highest paying job and z.ero allowances are

0 on his *or* her tax return. you cannot claim exemption Head of household. Generally, you can claim head claimed on the others.See Pub. 505 for details.

N from wtihholding if your income exceeds S1,050 and of household filing status on your tax return only if

includes more than $350 of unearned income (for you *are* unmarried and pay more than 50% of the Nonresident alien.I f you are a nonresident ahen,

|  |  |  |
| --- | --- | --- |
| xampie, interest and dividends). | costs of keeping up a home ror yourselland your dependent(s) or other qualifying individuals.See | see Notice 1392·Supplemental Form W-4  Instructions for Nonresident Aliens,before |
| *Excr>ptions.* An employee may be able to claim | Pub.SOt , Exemptions, Standard Oeducl ion,and | completing this form. |

.g

0a.

e

exemption from withholding even if the employee is a

dependent, ilthe employee: Filing Informatoi n.for Information. Check your withholding. Atter your Form W-4 takes

Tax credits. You can take projected tax credits into account effect,use Pub. 505 to see llow the amount you *are*

..\_ • Is age 65 or older, in fi\)Uring yo"' allowable number or withholding allowances. having withheld compares to your projected totaltax

0 • Is blind, or Credits tor child or dependent care expenses and tne child for 2015. See Pub. 505, especiallyif your earnings

.'g-;U

lax credit may be daimed using the Personal lowances exceed $130,000 (Single) or $180,000 (Married). Will claim adjustments toincome;tax credits: or Worksheet below. See Pub.505 tor information on Future developments.Information about any future

til >< ::>, itemized deductions. on his or her tax retum. convertni g your othEII" credits into wrthholding allowances. developments affecting Form W-4 {such os legislation

•

W 0 1: ------------------------------ -- -------- --;, -- - - -- eafdterwe r erl ew i llbpsteodat .i goww4.

0::: u. 0 Personal Allowances Worksheet (Keep for your records.)

+" ---------- -- -- ---- ---- ---- -------- -------- ------ -- -----

·:;;: :::.\_ § A Enter "1" for yourself i f no one el se can claim you as a dependent . **A**

0 u ·.;::; { •You are single and have only one job; or }

U. ro

:g",

•

:;:, B Enter "1" if:

You are married, have only one job, and your spouse does not work; or B

Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

m W c Enter "1" for your spouse.But, you may choose to enter·-o-"if you are married and have either a working spouse or more

o

i§ g- than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . c

w uu.

0 Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . D

E Enter "1"i f you will file as head of household on your tax return (see conditions under Head of household above) E F Enter "1" if you have at least $2,000 of chli d or dependent care expenses for which you plan to claim a credit F

(Note.Do not include child support payments. See Pub.503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub. 972,Child Tax Credit, for more information.

• If your total income will be less than $65,000 {$100.000 if married).enter "2" for each eligible child; then less "1" if you have two to four eligible chli dren or less "2" if you have five or more eligible children.

•If your total income will be between $65,000 and $84,000 ($100.000 and $119,000if married),enter "1" for each eligible ch d. G

H Add lines A through G and enter total here. {Note.This may be different from the number of exemptions you claim on your tax return.) .,.\_ **H**

For accuracy, j

complete all

• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.

If you are single and have more than one job or are marri ed and you and your spouse both work and the combni ed

worksheets that apply.

•

earnings from a!l jobs exceed $50,000 {$20,000 if marrei d), see the Two-Earners/Multiple Jobs Worksheet on page 2 to

avoid havni g too little tax withheld.

• If neither of the above situations appl ies, stop here and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Fonn W-4 to your employer. Keep the top part tor your records.

**Employee's Withholding Allowance Certificate** OMB No. 1&45-0074

**W-4**

**Form**

**@15**

**Department of the Treasury** Whether you are enti tled to claim a certain number of allowances or exemption from withholdni g is

**1(!1ernal Revenue- Service** subject to review by the IRS.Your employer may be required to send a copy of thsi form to theIRS.

1 Your first narne and middle initial

Last name 1 2 Your socai lsecurity number

I

Home address (number and street or rural route) 3 0 Single 0 Married 0 Married, but wtihhold at higher Single rate.

Note. If married. but legall y separated.or spouse is a nonr!sident al;eo, cneck the '"S•ngle'box. City or town. state. ad ZIP *code* **4 If your last name differs from that shown on your social security card.**

check here. Y ou must call1-800-772-1213 for a replacement card. .,.\_ 0

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) 5

6 Additional amount. if any. you want withheld from each paycheck 6 $

7 1 claim exemption from withholding for 2015, and I certify that Imeet both of the l ollowing conditions for exemption.

• Last year I had a right to a refund of all federal income tax withheld because Ihad no tax liability. and

• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, write "Exempt'' here .

..

... r11

Under penallies of pequry. I declare tt1at I have exam1ned th1s certlf tcate and. to the best of my knowledge and belief. 1t IS true.correct, and complete.

-

Employee's signature

(This forIS not valid unl s:.Ly:.o:.u s::i,\_g::\_n..:.it:o:-\_l..:.,. -:--..,---- - ..,-..,-- --:-:---:------:-= -:-:--.-:--cc-------- . ..D:\_a:...t..:e-=.,.. c-\_

8 Employers name and address (Employer: Complete lines a and 10 only if s nd<ng to the IRS.) 9 Off•ce cede :optional) 10 Employer Identification 11umber (EIN) American Pool, I nc. 3580 Progress Drive, Suite E, Bensalem, PA 19020 23-2860119

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cm. No. 102200 Form **W** -4 (2015)

**APPLICATION FOR EMPLOYMENT**



We are an Equal Opportunity Employer. All persons shall have the opportunity to be considered for employment without regard lo their race,color, religion, creed, nationalorigin, ancestry, alienage or citizenship status,age,disability, gender (including pregnancy, childbirth & related medicalconditions), sexual orientation,genetic characteristics, veteran or military status, marital status, or any other characteristic protected by applicable federal, state or localla ws.

We will endeavor to make a reasonable accommodation to the known physicalor mental limitations of a qualified applicant with a disability to assist in the hiring process, unless the accommodation would impose an undue hardship on the operation of our business, in accordance with applicable federal, state and local law. If you believe you require such assistance to complete this fonm or to participate in the interview process, please contact the office manager.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I 1 New Employee u Returning Employee | |  | | |
| **FIRST NAME:** | | **LAST NAME:** | | **MIDDLE NAME:** |
| Home Address: | | | Other Address (College/Summer, if applicable): | |
| City: State: Zip: | | | City: State: Zip: | |
| Telephone: | | | Telephone: | |
| Cell: | | | Date of Birth: | |
|  | Email: | | If you are less than 18 years of age, can you provide required proof  of your eligibility to work? u Yes u No | |

You are not required to furnish any information,which is prohibited by federal,state,or locallaw.

**JOB PREFERENCES**

What is your preferred position? II Lifeguard [ l Pool Manager n Supervisor I I Other: Desired Pay: Pool or desired area you would like to work:

**CERTIFICATIONS**

11 All my certifications are good through Labor Day

1 1 My certifications have already expired

1 1 One or more of my certifications expire before Labor Day

u I have never been certified

**HOW DID YOU LEARN ABOUT US?** (Please check one)

II Friend (First & Last Name:,

-' r Job Fair/Career Center ll Flyer/Mailer/Poster I Online Search

11 Facebook r I lndeed.com 11 Other u I am a returning employee

**PREVIOUS EXPERIENCE** (If you are a returning employee, **SKIP** to the Availability section.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Company: | | Kind of Business: | | |
| Address: | City: | State: | Zip: I Phone: |  |
| Position: | Pay rate: | | Employed from: To: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Supervisor: | | Reason for Leaving: | |  | |
| Company: | | Kind of Business: | | |  |
| Address: | City: | State: | Zip: I Phone: | |
| Position: | Pay rate: | | Employed from: To: | | |
| Name of Supervisor: | | Reason for Leaving: | | | |

**REFERENCE** (optional)

Name: Phone: Email: Relationship:

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**EDUCATION**

|  |  |  |
| --- | --- | --- |
| Name of High School: | Location: | Graduation Date: |
| College: | Major: | Graduation Date: |

**AVAILABILITY**

Desired number of hours you would like to work per week:

I am involved with regular activities (sports, band,

I **No** 11 Yes *Explain:*

classes) that may conflict with my schedule.

I will be able to work beginning

II Yes 1 **No** *Explain:*

Memorial Day Weekend.

I will be available to work weekends while school is in session.

II Yes I **No** *Explain:*

I will be available to work weekday afternoons

(after 4pm) while school is in session.

I I Yes 1 1 **No** *Explain:*

I will be able to work through Labor Day.

II Yes 1 **No** *My last day will be: / /*

*(Any changes to this date must be reported to the office)*

I currently have planned days off that may conflict with my schedule.\*

II **No** II Yes *Explain:*

\*All employees must adhere to standard policy procedures regarding vacation requests. This document is not considered a formal request

**SIGN** X.

Date: \_

**WHAT ABOUT YOUR FRIENDS?** Please list any friends/family that may be interested in working with us this summer.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | Email: | Phone: | Certified? I I Yes | I I No |
| Name: | Email: | Phone: | Certified? I I Yes | I I No |
| Name: | Email: | Phone: | Certified? I I Yes | II No |

A lifeguard,by definohon,has alegal dutylo prolecl he safely of people in an assigned area. Lifeguards have a professoonalobligation to prevent potentialaCCidcnsl by enforcing the rules and regulations of anaquabc **selling and to react to any emergencies that occur. To be a professional lifeguard, a person must have ccrta1n physical fitness, certif.calion of lifeguard tra1n1ng, first aid, card•opulmonary resuscitation and other rcqu•rcmcnts. wh.ch may be taik>rcd to the specifiC needs of the facility. Lifeguards must be able to perform the essential functions of the job with or without reasonable accommodation.**

**LEGAL/EMERGENCY**

In the case of an emergency,please notify: Phone:

Can you perform the essential functions of this job without reasonable accommodations?• I Yes l No

What, if any, accommodations are required?

Are you legally authorized to work in the United States?

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENSE THAT HAS NOT BEEN EXPUNGED, SEALED, PARDONED, ANNULLED, DISCHARGED, STATUTORILY ERADICATED OR DISMISSED UPON CONDITION OF PROBATION WITHIN THE LAST TEN YEARS?

I I Yes I No If so,when?

A criminalconvictoi n will not necessarily be a bar to employment. To help us evaluate your application, please describe the nature of the offense for which you were convicted, the circumstances surrounding the commission of the offense and your subsequent rehabilitation:

APPLICANrS STATEMENT

Ihave read and full y understand the queslions askedin this application. I certify that aU ollhe answers Ihave given arc true,accurale and complete Iunderstandlhalthe omission and/or omissoon and/or misrepo-esentalion of any faclfrom or on this application or during any inteovtew wolf rcsullon immcdoalc rc)CC!ion of my application or if I am hired will be cause for immediate dosmissal.Unless 1 noted otherwise,1 authorize the Company to contact an of *my* employment and personalreferences,as well as the education institutes l have allended. I further authorize lhc Company to inquioe abou,l invcstogate and obtain

copoes of any records whoch relate lo me from my former employers and educational onstotulions. l hereby release the Company and allaffi aled persons and entities,as well as any person or institution that provides the Company with *any* lawfulinfoomalion about me.from any and allloabolily whalsocvcr rcsulling from any such lawful inquioy. investigation or communication

If hired, I agree to abide by all the rules and regulations of the Company Iunderstand and agree lhalnolhing in lhis application shall conslilulc an offer, a contract or a guarantee of employment for a specifoc pcnod of limo. If hored, I understand that my employment may be terminated with or without cause or notice at any time,at the will of the Company or me. Ifurther understand that no representative

**or agent of the Company, other than the President, has the authority to enter into any agreement for employment for any specific period of time, or to make an agreement contrary to the foregoing. 1** also understand that any agreement modifying my at-will employment status must bein wr ting and signed by the President. In addition, Iunderstand that the Company and all plan administrators shall have tho maxomum doscrction pcrmillcd by law to administer, interpret, modify,disconhnue,enhance or otherwise change allpolicies, procedures. benefits or other tem>s and conditions of employment.

Iunderstand that any honng decision os contongcnlupon my successful completoon of all of the Company's lawfulpre-employment checks, which may include a background check l agree to execute any consent forms ncocssaoy for the Company lo conduct its lawful pre-employment checks.

Signature: Date: