



TBL
Security Services LLC

We are an Equal Opportunity Employer and committed to excellence through diversity.

Please print or type. The application must be fully completed to be considered. Please complete each section, even if you attach a resume.

Application For Employment

Personal Information

Name

D.O.B:

SSN:

Address

City

State

Zip

Phone number

Email address

Are you legally eligible to work in the US?

Yes ☐

No ☐

Are you a veteran?

Yes ☐

No ☐

If selected for employment are you willing to submit to a background check?

Yes ☐

No ☐

Position

Position you are applying for

Available start date

Desired pay

Employment desired

Full time ☐

Part time ☐

Seasonal/Temporary ☐

Education

School name	Location	Years attended	Degree received	Major

References (business and professional only)

Name	Title	Company	Phone

Employment History

Employer (1) 	Job title 		Dates employed
Work phone 	Starting pay rate 		Ending pay rate
Address 	City 	State 	Zip
Employer (2) 	Job title 		Dates employed
Work phone 	Starting pay rate 		Ending pay rate
Address 	City 	State 	Zip
Employer (3) 	Job title 		Dates employed
Work phone 	Starting pay rate 		Ending pay rate
Address 	City 	State 	Zip
Employer (4) 	Job Title 		Dates employed
Work phone 	Starting pay rate 		Ending pay rate
Address 	City 	State 	Zip
Employer (5) 	Job title 		Dates employed
Work phone 	Starting pay rate 		Ending pay rate
Address 	City 	State 	Zip

Signature Disclaimer

I certify that my answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my employment being terminated.

Name (please print) 	Signature
Date 	

☐ Check here if electronically signed by applicant.

Employee's Withholding Certificate

OMB No. 1545-0074

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.****2024****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.)		

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 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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (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):		
	Multiply the number of qualifying children under age 17 by \$2,000 \$ _____		
	Multiply the number of other dependents by \$500 \$ _____		
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$ _____
Step 4 (optional): 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. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$ _____

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
employmentEmployer identification
number (EIN)☐ Check here if electronically signed by applicant.



MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee's Name _____ SSN _____

Employee's Residence _____

Number and Street _____

City or Town _____

State _____

Zip Code _____

CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION			
Marital Status		Personal Exemption Allowed	Amount Claimed
EMPLOYEE:			
1. Single		☐ Enter \$6,000 as exemption ▶	\$
2. Marital Status (Check One)		(a) ☐ Spouse NOT employed: Enter \$12,000 ▶	\$
		(b) ☐ Spouse IS employed: Enter that part of \$12,000 claimed by you in multiples of \$500. See instructions 2(b) below. ▶	\$
3. Head of Family		☐ Enter \$9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d) below ▶	\$
EMPLOYER: Keep this certificate with your records. If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.		4. Dependents Number Claimed You may claim \$1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim \$1,500 for each dependent excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by \$1,500. Enter amount claimed... ▶	\$
		5. Age and blindness • Age 65 or older ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ Single Multiply the number of blocks checked by \$1,500. Enter the amount claimed ▶ * Note: No exemption allowed for age or blindness for dependents.	\$
		6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5... ▶	\$
		7. Additional dollar amount of withholding per pay period if agreed to by your employer ▶	\$
		8. If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write "Exempt" on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▶	_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____

Date: _____

☐ Check here if electronically signed by applicant. **INSTRUCTIONS**

1. The personal exemptions allowed:

- | | | | |
|-----------------------------------|----------|---------------------|---------|
| (a) Single Individuals | \$6,000 | (d) Dependents | \$1,500 |
| (b) Married Individuals (Jointly) | \$12,000 | (e) Age 65 and Over | \$1,500 |
| (c) Head of family | \$9,500 | (f) Blindness | \$1,500 |

2. Claiming personal exemptions:

(a) Single Individuals enter \$6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of \$12,000.

If the spouse is not employed, enter \$12,000 on Line 2(a). If the spouse is employed, the exemption of \$12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of \$500. For example, the taxpayer may claim \$6,500 and the spouse claims \$5,500; or the taxpayer may claim \$8,000 and the spouse claims \$4,000. The total claimed by the taxpayer and spouse may not exceed \$12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter \$9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of \$1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but

should not include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of \$1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by \$1,500 and enter amount of exemption claimed.

3. Total Exemption Claimed:

Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION.

6. IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENEFIT OF EXEMPTION.

To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9

OMB No.1615-0047

Expires 07/31/2026

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. A noncitizen (other than Item Numbers 2. and 3. above) 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** on Page 3.

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)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.			
Document Number (if any)					
Expiration Date (if any)					
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.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole 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. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record	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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.



**Supplement A,
Preparer and/or Translator Certification for Section 1**

**Department of Homeland Security
U.S. Citizenship and Immigration Services**

**USCIS
Form I-9
Supplement A**
OMB No. 1615-0047
Expires 07/31/2026

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code



Supplement B,
Reverification and Rehire (formerly Section 3)
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name (Family Name) from Section 1 .	First Name (Given Name) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)	New Name (if applicable)		
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.



Pre-employment Employment Questionnaire

Name: _____ Date: _____

1. Are you currently under a doctor's care? ☒ Yes ☐ No
2. Are you currently on workers 'compensation? ☒ Yes ☐ No
3. Are you currently on disability? ☒ Yes ☐ No.
4. Do you have any disabilities that would prevent you from standing for long periods of time? ☒ Yes ☐ No.
5. Do you have any disabilities that would prevent you from walking long distances? ☒ Yes ☐ No.
6. Have you ever been convicted of a felony? ☒ Yes ☐ No. If so, when, where, and for what?

7. Have you ever been convicted of any domestic violence crimes? ☒ Yes ☐ No. If so, when, where?

8. Do you have any physical conditions that would prevent you from carrying a firearm? ☒ Yes ☐ No.

9. Do you have a valid driver's license? ☒ Yes / ☐ No. If no, why?

10. Do you currently possess a legal marijuana card issued by a physician?

☒ Yes / ☐ No. If yes, a copy of the card will be placed into the employee folder.

11. Do you currently possess a valid concealed carry permit? ☒ Yes / ☐ No? If yes, when does it expire? _____

12. Can you lift and/or carry weight greater than 30 pounds? ☒ Yes / ☐ No

13. Can you climb a ladder? ☒ Yes / ☐ No.

14. Can you traverse stairs? ☒ Yes / ☐ No.

15. Do you ingest over the counter products not prescribed by a licensed physician, that contain CBD or THC?

☒ Yes / ☐ No.

I, _____ affirm that all the questions above were truthfully answered to the best of my knowledge. I acknowledge that any question that were intentionally answered falsely will nullify any and all agreements made between the applicant and TBL Security Services.

Applicant Signature

Date

☐ Check here if electronically signed by applicant.



Payroll Data Input Form

First Name: _____ MI: _____

Last Name: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____

Date of Birth: ____/____/____

SSN: _____

Gender: Male /Female/ Prefer Not to Say

Race: White / Hispanic /African American / Native American/ Prefer Not to Say

Primary Telephone Number: _____

Cell Phone Number: _____

Email Address: _____

Emergency Contact: _____

Phone Number: _____

Please choose one of the following preferences for tax purposes: (Note: Some positions will require a W-2 per the contract being worked.)

W-2 _____ 10-99 _____

If you currently work for a law enforcement agency, please provide the agency name:

_____ Minimum Standards# _____

Submit a copy of your Driver's License, Social Security Card, and Current Law Enforcement Credentials with this form.



In compliance with new guidelines set forth by the American Disabilities Act (ADA), TBL Security Services LLC has formulated a list of responsibilities, duties, and other requirements necessary for the position of security officer, and any other operational assignments. If you take a position with TBL Security Services LLC, the following will be required:

- **The ability to stand in a designated area for extended periods of time.**
- **The ability to walk through and observe various sites, both indoors and outdoors throughout your entire shift where obstacles may be present in the environment of the workplace.**
- **The ability to visually scan badges, ID cards, or any other documents.**
- **The ability to hear and respond to alarms, emergency sirens, warning devices, etc.**
- **The ability to comprehend, read, speak and utilize the English language in a clear, correct, and understandable fashion.**
- **The ability to restrain an individual or prevent an individual from entering/exiting a workplace, showroom, or any other assigned area.**
- **The ability to comprehend and implement both oral and written post orders/instructions.**
- **The ability to write various reports (Disciplinary, Incident, Injury, etc.) and take messages/notes.**
- **The ability to comprehend instructions of the correct usage of communication (radio, telephone, computer, etc.) and to effectively utilize communication equipment.**

Check One

_____ I acknowledge that I am physically and mentally capable of fulfilling and performing all the above-mentioned duties.

_____ I acknowledge that I am not physically or mentally capable of fulfilling and performing all the listed duties, however, I can perform with reasonable accommodation. That accommodation is:

_____.

_____ I acknowledge that I am not physically or mentally capable of fulfilling and performing the listed duties.

Signature: _____ **Date:** _____

☐ Check here if electronically signed by applicant.



Direct Deposit Authorization Form

I (we) hereby authorize TBL SECURITY SERVICES, hereinafter called COMPANY, to initiate credit entries to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Financial Institution Name

Branch

Address

City/State

Zip

Routing Number

Account Number

Type of Acct: ☒ Checking ☐ Savings

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it.

Print Individual Name

Signature

☐ Check here if electronically signed by applicant.

Apartment #

Date

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM



Payroll Statement of Understanding

Every new TBL employee will be provided with login information to access Officer Reports. It is the sole responsibility of the employee to ensure they clock in and clock out through the Officer Reports app to get paid correctly.

If an incident arises that the app does not allow you to clock in or clock out effectively then it is the sole responsibility of the employee to contact their Site Supervisor and inform them of the incident. If the incident is confirmed to be credible by the Site Supervisor, the employee will have their time corrected by a Regional Manager.

Individual paper time sheets will no longer be accepted or considered.

I, _____ understand and acknowledge the above statement.

Signature

Date

☐ Check here if electronically signed by applicant.



TBL SECURITY SERVICES NON-COMPETE AGREEMENT

1. Purpose This agreement, when countersigned below, shall constitute an agreement regarding certain confidential and proprietary information and trade secrets ("Confidential Information") relating to the business of TBL Security Services LLC. Hereinafter referred to as the "Company" and

_____ hereinafter referred to as the "Recipient" (collectively referred to as the "Parties"), as of the date executed by the Company (the "Effective Date"). Recipient shall strictly maintain the confidentiality of the Proprietary Information. Proprietary information may be shared between the Parties for use in scoping, estimating, and completing projects as well as for the everyday business practices for the Company and its clients/customers.

2. Non-Compete/Disclosure During the tenure of the Recipient with the Company and the Time Period stated in Section 3 the Recipient shall not: (Check All that Apply)

☐ - Business Practices - Provide the same or similar industry products, services, or engage in any other way representation of any other business of a similar nature to the business of the Company without written consent. It is understood that the Recipient will be representing the Company exclusively during their tenure unless written notice has been provided from either of the Parties.

☐ - Clients/Customers - Directly or indirectly engage in any similar business practice of the Company while being in contact with the Company's current or former clients. Nor shall the Recipient solicit any client of the Company for the benefit of a third party that is engaged in a similar business to that of the Company.

☐ - General Competitor(s) - Engage in business activity, whether paid or non paid, with a competitor of the Company that provides a similar product or service.

☐ - Specific Competitor(s) - Engage in business activity, whether paid or non-paid, with the following business(es) or individual(s): _____

☐ - Employees - Hire, work alongside, or partner with any current employees, sales staff, or former employees or sales staff of Company. Page 1 of 4 3. Time Period Recipient warrants and guarantees for the _____ period following the: (Check One) ☐ -

Effective Date of this agreement.

☐ - Termination of the Recipient's employment and/or business with the Company. 4. Purchase Option (Check One)

☐ - The Company shall allow the Recipient to void this agreement at any time and release all liability in connection with this agreement by payment to the Company in the amount of _____ US Dollars (\$_____).

☐ - The Company does not allow the Recipient to be released of liability from this agreement for any monetary amount or reason whatsoever.

5. Jurisdiction The jurisdiction of this agreement shall cover the areas of _____.

6. Confidential Information As used herein "Confidential Information" shall mean any and all technical and non-technical information provided by the Company, including but not limited to: data or other proprietary information relating to products, inventions, plans, methods, processes, know-how, developmental or experimental work, computer programs, databases, authorship, customer lists (including the names, buying habits or practices of any clients), the names of vendors or suppliers, marketing methods, reports, analyses, business plans, financial information, statistical information, or any other subject matter pertaining to any business of the Company or any its respective clients, consultants, or licensees that is disclosed to the Recipient under the terms of this Agreement.

7. Permitted Disclosure Confidential Information does not include information which: (i) Has become generally known to the public through no wrongful act by the Recipient; (ii) (iii) (iv) (v) Has been rightfully received by Recipient from a third party without restriction on disclosure and without breach of an obligation of confidentiality running either directly or indirectly to the Recipient; Has been approved for release to the general public by written authorization of the Company; Has been disclosed pursuant to the requirement of a governmental agency or a court of law without similar restrictions or other

protections against public disclosure; or, Has been independently developed by the Recipient without use, directly or indirectly of the Company's Confidential Information.

8. Confidentiality Recipient acknowledges that it will have access to the Company's Confidential Information and agrees that it shall not directly or indirectly divulge, disclose or communicate any of the Confidential Information to any third party, except as may be required in the course of any formal business association or dealings with the Company and in any event, only with the prior written approval of the Company. The Recipient acknowledges that no license of the Confidential Information, by implication or otherwise, is granted to the Recipient by reason of this Agreement. Additionally, the Recipient acknowledges that it may only use the Confidential Information in connection with its business dealings with the Company and for no other purpose without the prior written consent of the Company. The Recipient further agrees that all Confidential Information, including without limitation any documents, files, reports, notebooks, samples, lists, correspondence, software, or other written or graphic records provided by the Company or produced using the Company's Confidential Information, will be held strictly confidential and returned upon request to the Company. The term of this Agreement will be ongoing as long as the Parties are working together in any formal capacity. The conditions of this Agreement shall survive the termination of this Agreement.

9. Consultants and Employees Bound Recipient agrees to disclose the Confidential Information to any agents, affiliates, directors, officers or any other employees (collectively, the "Employees") solely on a need-to-know basis and represents that such Employees have signed appropriate non-disclosure agreements or taken appropriate measures imposing on such Employees a duty to third parties (1) to hold any third party proprietary information received by such Employees in the strictest confidence, (2) not to disclose such third party Confidential Information to any other third party, and (3) not to use such Confidential Information for the benefit of anyone other than to whom it belongs, without the prior express written authorization of the Company.

10. Return of Materials Upon termination or expiration of the Agreement, or upon written request of the Company, the Recipient shall promptly return to the Company all documents and other tangible materials representing the Company's Confidential Information and Page 3 of 4 all copies thereof. The Company shall notify immediately the Recipient upon discovery of any loss or unauthorized disclosure of the Confidential Information.

11. Remedies Should the Recipient breach any of the provisions of this Agreement by unauthorized use, or by disclosure of the Confidential Information to any unauthorized third party to the Company's detriment or damage, the Recipient agrees to reimburse the Company for any loss or expense incurred by the Company as a result of such use

or unauthorized disclosure or attempted disclosure, including without limitation court costs and reasonable attorney's fees incurred by the Company in enforcing the provisions hereof. Recipient further agrees that any unauthorized use of or disclosure of the Confidential Information will result in irreparable damage to the Company and that the Company shall be entitled to an award by any court of competent jurisdiction of a temporary restraining order and/or preliminary injunction against such unauthorized use or disclosure by the Recipient without the need to post a bond. Such remedies, however, shall not be deemed to be the exclusive remedies for any breach of this Agreement but shall be in addition to all other remedies available at law or equity.

12. Choice of Law This Agreement shall be governed by and construed in accordance with the laws of the State of Mississippi without reference to its conflicts of laws principles. Any disputes arising from or related to the subject matter of this Agreement shall be heard in a court of appropriate jurisdiction of the Company's principal office and the parties hereby consent to the personal jurisdiction and venue of these courts. If any provisions of this Agreement or its applications is held to be invalid, illegal or unenforceable in any respect, the validity, legality or enforceability of any other provisions and applications herein shall not in any way be affected or impaired.

13. Entire Agreement This Agreement represents the entire agreement of the parties and may only be modified by signature by both parties hereto. In Witness Whereof, the parties hereto have agreed and signed this

Non-Compete/Non-Disclosure Agreement to be on the ____ day of _____, 20____. The Company TBL Security Services llc.

Signature

Print Name and Title _____ Date

Recipient _____ Signature

Print Name _____ Date: _____

☐ Check here if electronically signed by applicant.



TBL COMPANY EMPLOYEE HANDBOOK **ACKNOWLEDGEMENT**

Received by: _____

Dated: _____

This handbook remains the property of TBL.

This Employee Handbook has been prepared to help each employee understand the policies of TBL, and to prevent any misunderstandings about the relationship between the employee and TBL, and its clients.

This acknowledgement shall be read, understood, signed and dated by the employee, and returned to TBL for filing. By signing, you acknowledge that you have thoroughly read the handbook in its entirety, understand it, and have had the opportunity to ask questions of TBL.

I understand that the TBL Employee Handbook is not a contract for employment. I understand that my employment with TBL is an “at-will” relationship, which means that both TBL and I have the right to terminate the employment relationship at any time, with or without cause or notice. I understand that the “at-will” nature of the employment relationship cannot be modified in any manner.

I understand and agree that this handbook may be unilaterally modified or amended by TBL at any time.

I agree to comply completely with all provisions and policies contained within this handbook.

Employee Signature:

Dated: _____

Witness:

☐ Check here if electronically signed by applicant.



Employee Health Insurance Disclosure Form

Employee Name: _____

Employee DOB: ____/____/____

Employee Social Security Number: _____-_____-_____

This is a disclosure that is stating that I either accept or deny Health Insurance coverage offered by TBL Security Services. By signing this statement I either accept the charges that come with the company's health coverage or acknowledge that I am responsible for my own medical treatments I receive.

☐

I accept health coverage that is offered by TBL Security Services and the cost for it each month.

☐

I decline health coverage at this time and I will be responsible for my own medical treatments.

Employee Signature: _____

Witness: _____

☐ Check here if electronically signed by applicant.

Height:

Weight:

Phone #:

Employee Information Sheet



PRODIGY
BENEFIT MANAGEMENT



Name: _____ Cell: _____

Address: _____ Zip: _____

SS#: _____ - _____ - _____ Email: _____

Date of Birth: _____ Gender: M F Tobacco Use: No Light Heavy

Occupation: _____ Employment Start Date: _____

Spouse Name: _____ Spouse DOB: _____ M / F

Spouse SS#: _____ - _____ - _____ Spouse Tobacco Use: No Light Heavy

Dependent Name: _____ DOB: _____ M / F

Dependent Name: _____ DOB: _____ M / F

Dependent Name: _____ DOB: _____ M / F

Dependent Name: _____ DOB: _____ M / F

Dependent Name: _____ DOB: _____ M / F

Who Do You Want Your Beneficiary to be?: _____ If Spouse, Check Here ☐

Beneficiary Name: _____ Relationship: _____

Check the box of the policy type you would like to have if there is any allotment left over after your life insurance policy: Critical Illness ☐ Accident ☐

Do you currently have an American Heritage or Allstate Life Insurance Policy? Yes No

If you have any questions, see your benefits advisor on site or call 866-826-5309.

I agree that my elections may be entered on my behalf based on the above information

Signature _____ Date _____

Everything Below This Line Is For Office Use ONLY. 

EMPLOYEE ALLOTTMENT

TOTAL PREMIUM



Employee Understanding and Disclosure

ATTENTIVE offers the ability to help you control costs of medical coverage and extend the allowance to you through your employer's Self-Insured Medical Reimbursement Plan (SIMRP), which focuses on Preventative Care Management© (PCM). You can receive reimbursement for your contribution by participating in the PCM Program.

Pre-tax contributions are made under the IRS Section 125 Cafeteria Plan. Standard tax savings are based on current state and federal income tax rates.

In accordance with your employer's Self-Insured Medical Reimbursement Plan (SIMRP), you may be reimbursed up to 100% of the premiums charged to you by your employer, if you meet certain criteria established by your employer.

I understand the savings and estimates are estimates; I should consult an accountant or tax expert. I further understand and acknowledge the Plan Administrator has entered a contractual arrangement with my employer and me.

I understand that if the total premium "After Tax Allotment" exceeds my "After Tax Allotment," the difference will be deducted from my current net pay. With signature below, I understand participation in the PCM Program requires me to login to my Personal Portal to fulfill my utilization requirements of 1 (One) per year. This may include, taking the health risk assessment, or when applicable, talking with a designated coach. All shared medical information is for my use only, and it will not be disclosed to my employer.

I further understand and agree to pay ATTENTIVE an administrative fee that will be deducted from the gross tax savings I may receive because of my pretax contribution.

I understand that failure to satisfy my participation requirements may lead to removal from the PCM Program and reimbursements of any premiums paid under the SIMRP may become taxable. I further understand that all Section 125 rules apply, and I cannot stop this plan until open enrollment each year, or in the case of a qualifying life change. Furthermore, participation in the PCM Program requires compliance regarding all HRA, HSA and FSA regulations. I understand the information above will be kept on file for ATTENTIVE's records and mine.

I also affirm that I have coverage for major medical insurance through an employer-sponsored plan.

I further understand that I will be emailed and/or SMS text once per month, pertaining my ATTENTIVE PROGRAM. (Msg & Data rates may apply)

Company Name: _____

☐ I wish to **participate** in the Attentive SIMRP program offered under the Section 125 plan

Signature _____ **Date** _____

Printed Name: _____ **Email:** _____

Date of Birth: _____ **Last 4 of Soc.Sec #:** _____ **Phone:** _____

Address: _____

Company Name: _____

☐ I wish to **decline to participate** in the Attentive SIMRP program offered under Section 125 plan

Signature: _____ **Date:** _____



Welcome to TBL Security Services.

_____ your starting pay will be
\$ _____/hr.

TBL will pay \$50.00 towards your, **gray in color, uniform pants** with the guarantee that you will not resign 90 days after signing this agreement. TBL will deduct the said amount from your last paycheck if this agreement is breached on your behalf. If you are terminated prior to the 90-day probationary period, the \$50.00 advancement will be deducted from your final check.

TBL will pay \$50.00 towards your, **black in color, uniform boots** with the guarantee that you will not resign 90 days after signing this agreement. TBL will deduct the said amount from your last paycheck if this agreement is breached on your behalf. If you are terminated prior to the 90-day probationary period, the \$50.00 advancement will be deducted from your final check.

*I, _____, acknowledge this proposal and accept/
decline the conditions set forth in the above paragraphs.*

Employee Signature: _____

Date: _____