

6
ORIGINAL

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE WORKERS COMPENSATION COMMISSION

Gene McCaskill, Commissioner
T. Scott Beck, Commissioner
Susan S. Barden, Commissioner

RECEIVED

WCC File No. 1510187
Appellate Case No. 2016-002297

JUN 30 2017

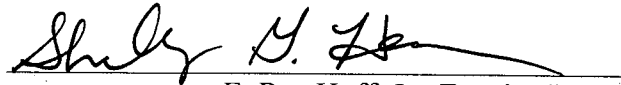
SC Court of Appeals

Shawn Wier, Employee, Claimant, Respondent,

v.

AGY Holding Corporation, Employer, and Great American Alliance Insurance
Company, Carrier, Appellants.

RECORD ON APPEAL
Volume II



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June 15, 2017

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Volume II

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Charlie Norwood VA Medical Center
1 Freedom Way
Augusta, GA 30904

SEP 21 2015

WIER, SHAWN ALLEN
2017 HONORS CIRCLE
GRANITEVILLE, SOUTH CAROLINA 29829

Dear SHAWN ALLEN WIER,

I want to update you on your recent test results. See how you do with on and off of the tennis elbow band. Let me know if no improvement and I will refer you to ortho.

IMAGING RESULTS
Image MRI Left Elbow
Impression:

Diffuse signal abnormality noted at the extensor tendon attachment to the lateral epicondyle, likely representing tendinopathy or possible partial tear.

Small joint effusion.

Tendonopathy at the attachment of the triceps tendon at the olecranon.

I have reviewed your lab results and have discussed above.

If you need health care for a medical problem prior to your next primary care appointment, please call the Call Center at 706-823-1717 or 888-483-9377 (toll free). The Call Center nurses will help you determine if you need to be seen on an emergency basis in the Emergency Department or whether we can help you in the group practice. Please do not just walk in to the clinic without an appointment. If we are not able to handle your problem over the phone, we will schedule you an appointment, usually within 24 hours of your call. The Call Center nurse line is also available after clinic hours and on weekends.

FUTURE APPOINTMENTS

10/13/2015 03:00 AUG EC OT THERAPY-OT6 UB
10/20/2015 12:30 AUG MR PC-INTER 3

In our efforts to help you stay healthy, I am including information on how you are doing with some prevention activities that, in the least, could stop you from getting sick and at the most could save your life. If you would like to address any of them or have any questions, please do not hesitate to contact me.

Clinical Reminder Due Report

STATUS DUE DATE LAST

DONE

Colorectal Cancer Screen

IN 2

Unknown

Page 2 of 2

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 07/06/2015

Encounter Sign-Off

Encounter signed-off by Mickey F. Plymale, MD, 07/08/2015.

Patient

Name	WEIR, SHAWN (27, M) ID# 379189	Appt. Date/Time	07/06/2015 09:30AM
DOB	[REDACTED]	Service Dept.	Lexington
Provider	MICKEY F. PLYMALE, MD		
Insurance	Med Worker's Comp: STRATEGIC COMP Employer Name: AGY AIKEN Case #: 247855408 Case Injury Date: 06/05/2015 Prescription: ESI1 - Member is eligible. details		

Chief Complaint

Followup: Lateral epicondylitis

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. He reports no loss of consciousness, no weakness, no numbness, no tingling, no seizures, no dizziness, no headaches, no migraines, and no restless legs.
ROS as noted in the HPI

HPI

Sports Follow-Up

Reported by patient.

How are you feeling? improving

Notes: patient is here for follow up for his left elbow, date of injury 6/5/15. He reports he feels better but he still has issues with lifting things. "It feels better but I can't lift anything over 8 lbs." He is currently at work at light duty.

Physical Exam

Patient is a 27-year-old male.

he has full ROM, still pain over the lateral epicondyle. Pain with elbow flexion but relatively good strength.

Previous Assessment / Plan

Date of Service

06/15/2015

Left elbow contusion. Plan is to stop with splint, tennis elbow strap, we will place on Medrol dose pak and place him on light duty for the next 3 weeks with no lifting over 10lbs.

1. Lateral epicondylitis - Left

726.32: Lateral epicondylitis

• X-RAY, ELBOW

Possibility of Pregnancy?: N Side: LEFT

• Medrol (Pak) 4 mg tablets in a dose pack - Take by oral route as directed. Qty: 1 package(s) Refills: 0

Pharmacy: WAL-MART PHARMACY 4487

• TENNIS ELBOW STRAP - Dispense Qty: 1 Unit

Assessment / Plan

Left elbow continued pain. I want to MRI his elbow as he says he can not lift heavy things right now. I will see him back after. I also want to place him in PT to strengthen his arm. Cont light duties and f/u after the MRI.

1. Contusion of elbow

923.11: Contusion of elbow

• PHYSICAL AND OCCUPATIONAL THERAPY REFERRAL - Schedule Within: provider's discretion

Note to Provider:

2-3x a week for 8 weeks for left elbow contusion

eval & treat-strengthening and ROM

• MRI, ELBOW - Note to Imaging Facility: MRI left elbow without contrast to eval for internal derangement

Side: LEFT

Contrast (MRI): Without

MRI type: Closed 1.5T min Possibility of Pregnancy?: N

Return to Office

None recorded.

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications	
Name	Date
naproxen 500 mg tablet Take 1 tablet(s) twice a day by oral route.	06/15/15 entered
Paxil 40 mg tablet Take 1 tablet(s) every day by oral route.	06/15/15 entered

Encounter performed and documented by Mickey F. Plymale, MD
Encounter reviewed & signed by Mickey F. Plymale, MD on 07/08/2015 at 1:02pm

Encounter Date: 06/15/2015

Encounter Sign-Off

Encounter signed-off by Mickey F. Plymale, MD, 06/17/2015.

Patient

Name WEIR, SHAWN (27, M) ID# 379189 Appt. Date/Time 06/15/2015 09:30AM
DOB [REDACTED] Service Dept. Lexington
Provider MICKEY F. PLYMALE, MD
Insurance Med Worker's Comp: STRATEGIC COMP
Employer Name : AGY AIKEN
Case # : 247855408
Case Injury Date : 06/05/2015
Prescription: ESI1 - Member is eligible. details

Chief Complaint

Left Elbow Problem

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. He reports no chest pain, no arm pain on exertion, no shortness of breath, no palpitations, no known heart murmur, and no lightheadedness. He reports no cough, no wheezing, no coughing up blood, no shortness of breath, and no sleep apnea. He reports no jaundice, no rashes, no itching, no dry skin, no growths/lesions, no skin ulcers, no hives, and no shingles. He reports no loss of consciousness, no weakness, no numbness, no tingling, no seizures, no dizziness, no headaches, no migraines, and no restless legs. He reports no swollen glands, no bruising, and no excessive bleeding.

ROS as noted in the HPI

Vitals

06/15/2015 09:39 am

Ht: 5 ft 9 in

Wt: 200 lbs

BMI: 29.5

BP: 127/81

HPI

Sports Elbow/Forearm
Reported by patient.

Location: left
Duration: date of onset: (6/5/15)
Timing: acute
Context: work injury
Aggravating Factors: carrying; pushing/pulling; ROM; weightbearing
Prior Imaging: x ray
Previous Injections: none
Previous PT: none
Work Related: yes

Notes: patient is here for evaluation of his left elbow. He reports that he was at work on 6/5/15 when he hit his elbow on a piece of equipment. He was seen later that day at Aiken Regional medical center where X-rays were taken. He was given naproxen and placed in a sugar tong splint and instructed to follow up with ortho. He is currently employed by AGY where he works producing fiberglass.

Physical Exam

Patient is a 27-year-old male.

Constitutional: General Appearance: healthy-appearing, NAD, active, alert and oriented, and normal body habitus.

Cardiovascular System: Arterial Pulses Right: radial normal. Arterial Pulses Left: radial normal. Capillary Refill Right: capillary refill test normal. Capillary Refill Left: capillary refill test normal.

Elbows: Inspection Right: no deformity, redness, swelling, or warmth. Inspection Left: no deformity, redness, swelling, or warmth. Bony Palpation Right: tenderness of the lateral epicondyle. Soft Tissue Palpation Right: no radial collateral ligament or ulnar collateral ligament. Passive Range of Motion Right: flexion normal, extension normal, pronation normal, and supination normal. Passive Range of Motion Left: flexion normal, extension normal, pronation normal, and supination normal. Strength Right: flexion 5/5, extension 5/5, pronation 5/5, and supination 5/5. Strength Left: flexion

5/5, extension 5/5, pronation 5/5, and supination 5/5.

Skin: Right Upper Extremity: normal. Left Upper Extremity: normal.

Neurologic: Sensation on the Right: C5-T1 normal. Sensation on the Left: C5- T1 normal.

Procedure Documentation

MFP Elbow Injection:

The patient was made aware of the risks of bleeding, infection, nerve damage, blood vessel damage, reaction to the medication, including skin changes and also the risk of elevated blood sugars if the patient was diabetic. I prepped the left elbow area with a betadine swabstick. I injected 3 cc's 0.25% Marcaine and 8 mg Dexamethasone with a 22 gauge needle without any complication. Adequate homeostasis was obtained afterwards. I told the patient to call if there were any problems.

Results / Interpretations

X-RAY, ELBOW

- Possibility of Pregnancy?: N, Side: LEFT

Review of x-ray, elbow taken on 06/15/2015 at MOORE CENTER FOR ORTHOPEIDICS shows:

Adult Elbow:

X-Ray: no fracture, no dislocation, joint spaces well preserved, and normal alignment.

Assessment / Plan

Left elbow contusion. Plan is to stop with splint, tennis elbow strap, we will place on Medrol dose pak and place him on light duty for the next 3 weeks with no lifting over 10lbs.

1. Lateral epicondylitis - Left

726.32: Lateral epicondylitis

• X-RAY, ELBOW

Possibility of Pregnancy?: N Side: LEFT

- Medrol (Pak) 4 mg tablets in a dose pack - Take by oral route as directed. Qty: 1 package(s) Refills: 0

Pharmacy: WAL-MART PHARMACY 4487

- TENNIS ELBOW STRAP - Dispense Qty: 1 Unit

Return to Office

- Mickey F. Plymale, MD for Work Comp Recheck at Lexington on 07/06/2015 at 09:30 AM

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications	
Name	Date
Medrol (Pak) 4 mg tablets in a dose pack Take by oral route as directed.	06/15/15 prescribed
naproxen 500 mg tablet Take 1 tablet(s) twice a day by oral route.	06/15/15 entered
Paxil 40 mg tablet Take 1 tablet(s) every day by oral route.	06/15/15 entered

Encounter performed and documented by Mickey F. Plymale, MD

Encounter reviewed & signed by Mickey F. Plymale, MD on 06/17/2015 at 7:21am

Consult Orders

MOORE CENTER
 FOR ORTHOPEDICS
Referral Order

07/06/2015

To Provider	From Provider
Phone: Fax:	Lexington 104 Saluda Pointe Drive Lexington, SC 29072-7295 Phone: (803) 227-8000 Fax: (803) 227-8015

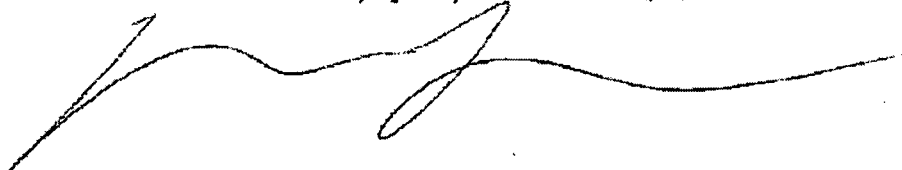
Referral Order Information

Diagnosis	Contusion of elbow ICD-9: 923.11: Contusion of elbow
Order Name	Orders Included: 1 Contusion of elbow ICD-9: 923.11: Contusion of elbow • PHYSICAL AND OCCUPATIONAL THERAPY REFERRAL Schedule Within: provider's discretion Note to Provider: 2-3x a week for 8 weeks for left elbow contusion eval & treat-strengthening and ROM
Notes	2-3x a week for 8 weeks for left elbow contusion eval & treat-strengthening and ROM

Patient Information

Patient Name	WIER, SHAWN
Sex - DOB - Age	M [REDACTED] 27 YR
Address	2017 HONORS CIRCLE GRANITEVILLE, SC 29829
Phone	H: (757) 867-3938 M: (757) 867-3938
Primary Insurance	STRATEGIC COMP Policy Holder: AGY AIKEN
Secondary Insurance	None recorded.

Electronically Signed by: MICKEY F. PLYMALE, MD



Electronically ordered/documentated by: MICKEY F. PLYMALE, MD

Letters

MOORE CENTER FOR ORTHOPEDICS

104 Saluda Pointe Drive
Lexington, SC 29072-7295
Phone: (803) 227-8000, Fax: (803) 227-8015

FOOT AND ANKLE
W. Bret Smith, D.O., M.S.
Ryan M. Putnam, M.D.

PEDIATRICS
Mark D. Locke, M.D.
Christopher R. Hyndem, M.D.
Michael P. Horan, M.D., M.S.

SPINE
William T. Felmy, M.D.
Michael W. Peele, M.D.
W. Alane Van Dusen, M.D.
John Clovet, M.D.
Jacquelyn F. Van Dam, M.D.

SPORTS MEDICINE
S. Wendell Holmes Jr., M.D.
Frank K. Nopjan II, M.S.
Mickey F. Plymale, M.D.
David A. Scott, M.D.

JOINT REPLACEMENT
Kim J. Chibag, M.D.
Bradley P. Prosser, M.D.
Jeffrey S. Hopkins, M.D.
UPPER EXTREMITY
Earl B. McFadden Jr., M.D.
David B. Fulton, M.D.

REPORT OF MEDICAL EXAMINATION

Shawn Weir

Employee's Name

Social Security Number

STRATEGIC COMP 247855408

07/06/2015

Employer/Carrier

Date of Office Visit

RETURN TO WORK STATUS:

_____ Regular Duties
_____ ☒ Light Duties
_____ Remain Out of Work

_____ Date to Return
_____ 7/6/15 Date to Return
_____ Duration

PHYSICAL LIMITATIONS:

_____ None
_____ No Walking or climbing
_____ No standing
_____ No prolonged standing
_____ No sitting
_____ No bending or stooping
_____ No twisting or stretching
_____ No change from previous status

_____ ☒ Pushing and pulling limit 10 lbs.
_____ ☒ Lifting and carrying limit 10 lbs.
_____ Sedentary duties only
_____ No kneeling, squatting, crawling
_____ No work involving _____ arm/hand
_____ No overhead work
_____ No work at heights
_____ Other: _____

FOLLOW UP:

_____ Days
_____ Weeks
_____ Months

_____ Discharged with limitations above
_____ PRN
Next Appointment: follow up after MRI left
elbow

Electronically Signed by: MICKEY F. PLYMALE, MD

MOORE CENTER FOR ORTHOPEDICS

104 Saluda Pointe Drive
Lexington, SC 29072-7295
Phone: (803) 227-8000, Fax: (803) 227-8015

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John Clavel, M.D.
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UPPER EXTREMITY
Earl B. McFadden Jr., M.D.
David B. Fulton, M.D.

REPORT OF MEDICAL EXAMINATION

Shawn Weir

Employee's Name

Social Security Number

STRATEGIC COMP 247855408

06/15/2015

Employer/Carrier

Date of Office Visit

RETURN TO WORK STATUS:

Regular Duties
☒ Light Duties
Remain Out of Work

Date to Return
6/16/15 Date to Return
Duration

PHYSICAL LIMITATIONS:

None
No Walking or climbing
No standing
No prolonged standing
No sitting
No bending or stooping
No twisting or stretching
No change from previous status

☒ Pushing and pulling limit 10 lbs.
☒ Lifting and carrying limit 10 lbs.
Sedentary duties only
No kneeling, squatting, crawling
No work involving arm/hand
No overhead work
No work at heights
Other:

FOLLOW UP:

Days
3 Weeks
Months

Discharged with limitations above
PRN
Next Appointment: 7/9/15 at 9:30AM

Electronically Signed by: MICKEY F. PLYMALE, MD

Prescription Documents

MOORE CENTER
 FOR ORTHOPEDICS

Approved Prescriber
 Date Renewed: 06/12/2015

Pharmacy	Prescriber
WAL-MART PHARMACY 4487 3581 RICHLAND AVE SW AIKEN, SC 29803 Phone: (803) 648-6464 Fax: (803) 648-6840	Moore Orthopaedic Clinic 104 Saluda Pointe Drive Lexington, SC 29072-7295 Phone: (803) 227-8000 Fax: (803) 227-8015

Prescription Information

Medication	Medrol (Pak) 4 mg tablets in a dose pack
Quantity	1 (one) package(s)
SIG	Take by oral route as directed.
Refills Allowed	No Refills
DAW7	N
Note to Pharmacy	

Patient Information

Patient Name	WIER, SHAWN
Sex - DOB - Age	M - 27 YR
Address	2017 HONORS CIRCLE GRANITEVILLE, SC 29829
Phone	H: (757) 887-3938 A: (757) 887-3938
Primary Insurance	STRATEGIC COMP Policy Holder: AGY AIKEN
Secondary Insurance	None recorded.

Dispense as Written	Substitutions Permitted

MICKEY F. PLYMALE, MD

DEA# FP2495756

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

DOCUMENT NAME: ED Physician Record
SERVICE DATE/TIME: 6/6/2015 00:46 EDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Sink PA, Mark H (6/6/2015 00:49 EDT)
SIGN INFORMATION: High MD, Aaron L (6/7/2015 19:36 EDT); Sink PA, Mark H (6/6/2015 01:36 EDT)

Elbow Injury - Minor

Patient: WIER, SHAWN A MRN: AIK341692 FIN: AIK0000116936964
Age: 27 years Sex: Male DOB: [REDACTED]
Associated Diagnoses: None
Author: Sink PA, Mark H

Basic Information

Time seen: Date & time 6/6/2015 00:27:00, Provider Assignment
Sink PA, Mark H assigned at 06/06/2015 00:27

History source: Patient.

Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint
6/5/2015 23:23 EDT Chief Complaint c/o lt elbow pain. when picking item up at work tonight hit lt elbow on "hard piece of plastic"

History of Present Illness

The patient presents with left, arm injury. The onset was 6 hours ago. The course/duration of symptoms is constant. Type of injury: direct blow. The location where the incident occurred was at work. Location: Left posterior lateral elbow. The character of symptoms is pain and swelling. The degree of pain is moderate. The degree of swelling is minimal. There are exacerbating factors including activity, movement and palpation. The relieving factor is immobilization. Risk factors consist of none. The patient's dominant hand is the right hand. Prior episodes: none. Therapy today: none. Associated symptoms: none. Additional history: notes that he was lifting up something at work and hit his elbow really hard.

Review of Systems

Constitutional symptoms: Negative except as documented in HPI.
Skin symptoms: Negative except as documented in HPI.
Eye symptoms: Negative except as documented in HPI.
ENMT symptoms: Negative except as documented in HPI.
Respiratory symptoms: Negative except as documented in HPI.
Cardiovascular symptoms: Negative except as documented in HPI.
Gastrointestinal symptoms: Negative except as documented in HPI.
Genitourinary symptoms: Negative except as documented in HPI.
Musculoskeletal symptoms: Joint pain.
Neurologic symptoms: Negative except as documented in HPI.
Psychiatric symptoms: Negative except as documented in HPI.
Endocrine symptoms: Negative except as documented in HPI.
Hematologic/Lymphatic symptoms: Negative except as documented in HPI.
Allergy/immunologic symptoms: Negative except as documented in HPI.
Additional review of systems information: All other systems reviewed and otherwise negative.

Health Status

Allergies:

Allergic Reactions (All)

No Known Allergies.

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
 MRN: AIK341692
 DOB/Sex: [REDACTED] / Male
 Attending: High MD, Aaron L

Admit: 6/5/2015
 Disch: 6/6/2015
 FIN: AIK0000116936964

Emergency Dept

Past Medical/ Family/ Social History

Surgical history:

No active procedure history items have been selected or recorded..

Family history:

No family history items have been selected or recorded..

Physical Examination

Vital Signs

Vital Signs (ST)

<u>Vital Signs (24 hrs)</u>	<u>Last Charted</u>	<u>Minimum</u>	<u>Maximum</u>
Temp	36.8 (JUN 05 23:23)	36.8 (JUN 05 23:23)	36.8 (JUN 05 23:23)
Peripheral Pulse Rate	L 58 (JUN 05 23:23)	L 58 (JUN 05 23:23)	L 58 (JUN 05 23:23)
Resp Rate	16 (JUN 05 23:23)	16 (JUN 05 23:23)	16 (JUN 05 23:23)
SBP	129 (JUN 05 23:23)	129 (JUN 05 23:23)	129 (JUN 05 23:23)
DBP	73 (JUN 05 23:23)	73 (JUN 05 23:23)	73 (JUN 05 23:23)
SpO2	99 (JUN 05 23:23)	99 (JUN 05 23:23)	99 (JUN 05 23:23)
	Room air	Room air	Room air

Per nurse's notes.

Oxygen saturation.

General: Alert, no acute distress.

Skin: Warm, dry, pink, intact.

Head: Normocephalic.

Neck: Trachea midline.

Eye: Pupils are equal, round and reactive to light.

Cardiovascular: Normal peripheral perfusion, No edema.

Respiratory: Respirations are non-labored.

Chest wall: No tenderness, No deformity.

Musculoskeletal: Normal ROM, Proximal upper extremity: Left, posterior, lateral, elbow, olecranon, tenderness, range of motion (limited, active, passive, on extension, restricted by pain).

Gastrointestinal: Soft, Nontender, Non distended.

Neurological: Alert and oriented to person, place, time, and situation, No focal neurological deficit observed, CN II-XII intact, normal sensory observed, normal motor observed, normal speech observed.

Lymphatics: No lymphadenopathy.

Psychiatric: Cooperative, appropriate mood & affect.

Medical Decision Making

Differential Diagnosis: Fracture, sprain, strain, contusion.

Orders Launch Orders

Patient Care:

Sling (Order): 6/6/2015 1:34 EDT, Routine, Left

Splint Forearm - Sugar Tong (Order): 6/6/2015 1:34 EDT, Routine, Left, Review/Insert Order Profile (Selected)

Inpatient Orders

Ordered (Exam Ordered)

XR Elbow Complete Left:

Elbow x-ray findings Normal alignment, no fracture, interpretation by Emergency Physician, Anterior fat pad sign without obvious fracture.

Impression and Plan

Print Date/Time 8/28/2015 13:00 EDT

Medical Record

Page 4 of 30

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Diagnosis

Arm pain 729.5 - ICD9 729.5,
Contusion of the elbow 923.11 - ICD9 923.11,

Plan

Condition: Improved, Stable.

Prescriptions: Launch PrescriptionWriter

Pharmacy:

Naprosyn 500 mg oral tablet (Prescribe): 500 mg, 1 Tabs, Oral, BID, 20 Tabs, PRN, as needed for inflammation
Norco 5 mg-325 mg oral tablet (Prescribe): 2 Tabs, Oral, q4H, may take 1 to 2 tabs per dose, 36 Tabs, PRN, for pain
Work Restrictions: Left Arm (Prescribe): 1 Each, Misc, Once, Please allow patient to work with sling and no use of left arm until orthopedic clearance., 1 Each.

Patient was given the following educational materials: CONTUSION, Elbow, ELBOW FRACTURE, SLING.

Limitations: Limited activity, Limited work.

Follow up with: Dr No pcp no family Within 1-2 days; AIK- CMI-Orthopedics Within 3-5 days.

Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Regarding prescription, Patient indicated understanding of instructions.

Disposition: Launch Disposition Order

Admit/Transfer/Discharge:

Discharge Request (Order): 6/6/2015 1:36 EDT, Home Routine.

Electronically Signed By: Sink, Mark PA

On: 06.06.2015 01:36 EDT

Electronically Signed On: 06.07.2015 19:36 EDT

High, Aaron MD

DOCUMENT NAME:

SERVICE DATE/TIME:

RESULT STATUS:

PERFORM INFORMATION:

SIGN INFORMATION:

Triage Note

6/6/2015 01:36 EDT

Auth (Verified)

Housley RN, Korie A (6/6/2015 01:36 EDT)

Housley RN, Korie A (6/6/2015 01:36 EDT)

ED Languages Entered On: 6/6/2015 1:36 EDT

Performed On: 6/6/2015 1:36 EDT by Housley RN, Korie A

Languages

Preferred Languages: English

Housley RN, Korie A - 6/6/2015 1:36 EDT

DOCUMENT NAME:

SERVICE DATE/TIME:

RESULT STATUS:

PERFORM INFORMATION:

SIGN INFORMATION:

Triage Note

6/6/2015 01:36 EDT

Auth (Verified)

Housley RN, Korie A (6/6/2015 01:36 EDT)

Housley RN, Korie A (6/6/2015 01:36 EDT)

ED Abuse/Neglect Adult Entered On: 6/6/2015 1:36 EDT

Performed On: 6/6/2015 1:36 EDT by Housley RN, Korie A

Print Date/Time 8/28/2015 13:00 EDT

Medical Record

Page 5 of 30

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Abuse/Neglect Assessment

Threatened/Physically Hurt in past year : No
ED DV Harm or Neglect Question : No
Abuse and Neglect Types : None

Housley RN, Korie A - 6/6/2015 1:36 EDT

DOCUMENT NAME:	Triage Note
SERVICE DATE/TIME:	6/6/2015 01:35 EDT
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Housley RN, Korie A (6/6/2015 01:35 EDT)
SIGN INFORMATION:	Housley RN, Korie A (6/6/2015 01:35 EDT)

ED Social History Entered On: 6/6/2015 1:36 EDT
Performed On: 6/6/2015 1:35 EDT by Housley RN, Korie A

Social History

Smoking History--MU : Current every day smoker
Tobacco Use Last 30 Days : Yes
Cultural Practices to be honored? : No

Housley RN, Korie A - 6/6/2015 1:35 EDT

Social History

(As Of: 6/6/2015 01:36:28 EDT)

Alcohol: Denies Alcohol Use
(Last Updated: 6/6/2015 01:36:11 EDT by Housley RN, Korie A)

Tobacco: Cigarettes, 10 per day. (Last Updated: 6/6/2015 01:36:16 EDT
by Housley RN, Korie A)

Tobacco Use Screening

Tobacco Use Screening : 5 or more cigarettes a day (1/4 pack or more)

Housley RN, Korie A - 6/6/2015 1:35 EDT

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

DOCUMENT NAME: Triage Note
SERVICE DATE/TIME: 6/6/2015 01:35 EDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Housley RN, Korie A (6/6/2015 01:35 EDT)
SIGN INFORMATION: Housley RN, Korie A (6/6/2015 01:35 EDT)

ED Triage General/Screening Adult Entered On: 6/6/2015 1:35 EDT
Performed On: 6/6/2015 1:35 EDT by Housley RN, Korie A

General/Screenings Adult
Suicide Assessment : None
Document Fall Risk Screening : Pass

Housley RN, Korie A - 6/6/2015 1:35 EDT

DOCUMENT NAME: Triage Note
SERVICE DATE/TIME: 6/6/2015 01:35 EDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Housley RN, Korie A (6/6/2015 01:35 EDT)
SIGN INFORMATION: Housley RN, Korie A (6/6/2015 01:35 EDT)

ED Triage RFV/Problems Entered On: 6/6/2015 1:35 EDT
Performed On: 6/6/2015 1:35 EDT by Housley RN, Korie A

Reason for Visit/Medical History ED
Reviewed Past Medical HX with Patient : Yes

Housley RN, Korie A - 6/6/2015 1:35 EDT
(As Of: 6/6/2015 01:35:32 EDT)

Diagnoses(Active)

Arm pain 729.5 Date: 6/6/2015 ; Diagnosis Type: Discharge ; Confirmation: Confirmed ; Clinical Dx: Arm pain 729.5 ; Classification: Medical ; Clinical Service: Emergency medicine ; Code: ICD-9-CM ; Probability: 0 ; Diagnosis Code: 729.5
Contusion of the elbow 923.11 Date: 6/6/2015 ; Diagnosis Type: Discharge ; Confirmation: Confirmed ; Clinical Dx: Contusion of the elbow 923.11 ; Classification: Medical ; Clinical Service: Emergency medicine ; Code: ICD-9-CM ; Probability: 0 ; Diagnosis Code: 923.11
Elbow injury - Minor Date: 6/6/2015 ; Diagnosis Type: Reason For Visit ; Confirmation: Confirmed ; Clinical Dx: Elbow injury - Minor ; Classification: Medical ; Clinical Service: Emergency medicine ; Code: PNED ; Probability: 0 ; Diagnosis Code: 0A483F98-9755-4E04-90DB-26BB69532A6C

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

DOCUMENT NAME:
SERVICE DATE/TIME:
RESULT STATUS:
PERFORM INFORMATION:
SIGN INFORMATION:

Triage Note
6/5/2015 23:23 EDT
Auth (Verified)
Hanlin RN, Sue Ann A (6/5/2015 23:23 EDT)
Hanlin RN, Sue Ann A (6/5/2015 23:23 EDT)

ED Triage Vitals Entered On: 6/5/2015 23:23 EDT
Performed On: 6/5/2015 23:23 EDT by Hanlin RN, Sue Ann A

ED Vitals

Systolic Blood Pressure : 129 mmHg
Diastolic Blood Pressure : 73 mmHg
BP Site : Right arm
Peripheral Pulse Rate : 58 bpm (LOW)
O2 Therapy : Room air
Respiratory Rate : 16 br/min
SpO2 : 99 %
Temperature : 36.8 DegC
Temperature Convert C to F : 98.2 DegF
Temperature Method : Oral

Hanlin RN, Sue Ann A - 6/5/2015 23:23 EDT

DOCUMENT NAME:
SERVICE DATE/TIME:
RESULT STATUS:
PERFORM INFORMATION:
SIGN INFORMATION:

Triage Note
6/5/2015 23:23 EDT
Auth (Verified)
Hanlin RN, Sue Ann A (6/5/2015 23:23 EDT)
Hanlin RN, Sue Ann A (6/5/2015 23:23 EDT)

ED Triage Primary Pain Assessment Entered On: 6/5/2015 23:23 EDT
Performed On: 6/5/2015 23:23 EDT by Hanlin RN, Sue Ann A

Primary Pain

Numeric Rating : 10 = Worst possible pain
Primary Pain Location : Elbow
Laterality : Left

Hanlin RN, Sue Ann A - 6/5/2015 23:23 EDT

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

DOCUMENT NAME:	ED Patient Education Note
SERVICE DATE/TIME:	6/6/2015 01:59 EDT
RESULT STATUS:	Modified
PERFORM INFORMATION:	Housley RN, Korie A (6/6/2015 01:59 EDT)
SIGN INFORMATION:	Housley RN, Korie A (6/6/2015 01:59 EDT); Sink PA, Mark H (6/6/2015 01:36 EDT)

ED Patient Education Note

SPECIAL INSTRUCTIONS FOR HANDLING YOUR MEDICATIONS

It is very important to take your medications as directed. In addition, you should provide a list of your medications to your primary care Physician. Your medication list should be updated when medications are changed or discontinued and when new medications are added (including over the counter medications). Carry your medication list with you at all times as this can provide very valuable information in the event you are involved in an emergency situation.

Please be sure to bring your medication list with you anytime you visit the Emergency Department.

FOLLOW UP with your doctor or as advised by our staff. If you do not have your own doctor, we can recommend one for you.

To find additional information about the medications you are taking, you can visit the following website - ConsumerMedSafety.org.

Diagnosis

CONTUSION, ELBOW

A contusion of your elbow causes local pain, swelling and sometimes bruising. There are no broken bones. This injury takes a few days to a few weeks to heal. A sling may be provided for comfort and arm support

HOME CARE :

1. Keep your arm elevated to reduce pain and swelling. This is most important during the first 48 hours after injury.
2. Apply an ice pack (ice cubes in a plastic bag, wrapped in a towel) over the injured area for 20 minutes every 1-2 hours the first day. You should continue with ice packs 3-4 times a day for the next two days. Continue the use of ice packs for relief of pain and swelling as needed.
3. You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another pain medicine was prescribed. **[NOTE:** If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.]
4. If a sling was provided, you may remove it to shower or bathe. Do not wear it for more than one week or it may cause joint stiffness.

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

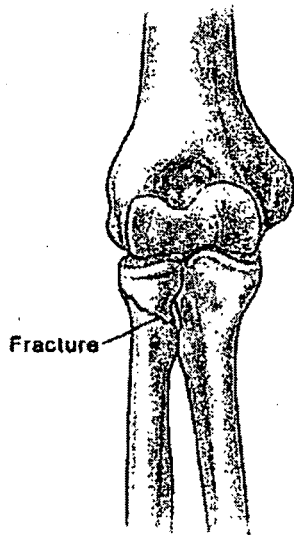
FOLLOW UP with your doctor or as advised by our staff if you are not starting to improve within the next three days.

GET PROMPT MEDICAL ATTENTION if any of the following occur:

- Pain or swelling increases
 - Redness, warmth or drainage
- Hand or fingers becomes cold, blue, numb or tingly

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FRACTURE: ELBOW



You have a break (fracture) of the elbow. This may be a small crack in the bone; or a major break with the broken parts pushed out of position.

This fracture usually takes 4-12 weeks to heal, depending on the type. Initial treatment is with a splint or cast. Severe fractures may require surgery to put the bone fragments back into place.

HOME CARE:

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

1. Keep your arm elevated to reduce pain and swelling. When sitting or lying down elevate your arm above the level of your heart. You can do this by placing your arm on a pillow that rests on your chest or on a pillow at your side. This is most important during the first 48 hours after injury.
2. Apply an ice pack (ice cubes in a plastic bag, wrapped in a towel) over the injured area for 20 minutes every 1-2 hours the first day. You can place the ice pack inside the sling and directly over the splint/cast. Continue with ice packs 3-4 times a day for the next two days, then as needed for the relief of pain and swelling.
3. Keep the splint/cast completely dry at all times. Bathe with your splint/cast out of the water, protected with a large plastic bag, rubber-banded at the top end. If a fiberglass splint/cast gets wet, you can dry it with a hair-dryer.
4. You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another pain medicine was prescribed. [NOTE: If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.]

FOLLOW UP with your doctor in one week, or as advised by our staff, to be sure the bone is healing properly. If a splint was applied, it will be changed to a cast during your follow-up visit.

[NOTE: A radiologist will review any X-rays that were taken. We will notify you of any new findings that may affect your care.]

GET PROMPT MEDICAL ATTENTION if any of the following occur:

- The plaster cast or splint becomes wet or soft
 - The fiberglass cast or splint remains wet for more than 24 hours
 - Increased tightness or pain under the cast or splint
- Fingers become swollen, cold, blue, numb or tingly

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Medication

MEDICATION: NAPROXEN

Naproxen (brand names: Naprosyn, Anaprox, Aleve, Naprelan, Pamprin, Midol) is an anti-inflammatory drug which is very useful for pain and inflammatory conditions.

DIRECTIONS FOR USE:

You may take this medicine with food to reduce stomach upset.

WHAT TO WATCH FOR:

POSSIBLE SIDE EFFECTS: Nausea, upper abdominal pain, drowsiness, dizziness, ringing in the ears (Contact your doctor if these symptoms persist or become severe). Bleeding from the stomach, which may appear as blood in vomit or

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

stool (red or black color); rapid weight gain, leg swelling or easy bruising, change in the amount of urine, confusion/mood changes, very stiff neck, yellowing of the eyes/skin (Contact your doctor or return to this facility promptly).

ALLERGIC REACTION: Rash, itching, swelling, trouble breathing or swallowing (Contact your doctor or return to this facility promptly).

MEDICAL CONDITIONS: Before starting this medicine, be sure your doctor knows if you have any of the following conditions:

- Stomach ulcer (active or in the past), history of vomiting blood or bloody stools
- Allergic reaction to aspirin or other anti-inflammatory medicines
- Asthma, nasal polyps or angioedema; pregnancy or breastfeeding
- Liver or kidney disease; bleeding disorder, diabetes

DRUG INTERACTION: Before starting this medicine, be sure your doctor knows if you are taking any of the following drugs:

- Blood thinners [Coumadin (warfarin), low molecular weight heparins, heparin], cyclosporine, diuretics (water pills), blood pressure pills, ACE inhibitors (Lotensin, Capoten, Vasotec, Zestril, and others), diabetes pills, steroids (methylprednisolone, prednisone), aspirin or other anti-inflammatory drugs, methotrexate, probenecid, cidofovir, antiplatelet drugs such as Plavix (clopidogrel) or Plavix (clopidogrel), desmopressin, drugs for osteoporosis [Fosamax(alendronate)], lithium, pemetrexed, bile acid binding resins, drotrecogin, SSRI antidepressants (fluoxetine, sertraline)

WARNINGS:

- Do not take with prednisone, other anti-inflammatory drugs, or alcohol since this increases the risk of getting a bleeding ulcer.
- Do not drive, ride a bicycle, or operate dangerous equipment while taking this medicine until you know how it will affect you.

[NOTE: This information topic may not include all directions, precautions, medical conditions, drug/food interactions, and warnings for this drug. Check with your doctor, nurse, or pharmacist for any questions that you may have.]

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MEDICATION: HYDROCODONE + ACETAMINOPHEN

Hydrocodone/acetaminophen (brand names: Vicodin, LorTab, Anexsia, Norco) is a narcotic pain medicine This medicine contains Tylenol (acetaminophen).

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

DIRECTIONS FOR USE:

If this medicine upsets your stomach, take it with food or milk. Pain medication should be taken only if needed at the times prescribed. If you are not having pain, do not take the medicine unless you are advised to do so by your doctor.

Do not take more than 4 grams (4,000 mg) of acetaminophen (Tylenol) per 24 hours.

WHAT TO WATCH FOR:

POSSIBLE SIDE EFFECTS: Dizziness, drowsiness (Take a smaller dose; for example, break the pill in half or take it less often). Constipation (Drink lots of liquids, use small doses of a mild laxative like milk of magnesia, as needed). Nausea, vomiting (Take with food or milk). Difficulty passing urine (Stop the medicine and contact your doctor).

ALLERGIC REACTION: Rash, itching, swelling, trouble breathing or swallowing (Contact your doctor or return to this facility promptly).

MEDICAL CONDITIONS: Before starting this medicine, be sure your doctor knows if you have any of the following conditions:

- Prostate enlargement
- Lung disease (asthma, COPD)
- Allergy to aspirin or other salicylates
- Intestinal obstruction or severe constipation
- Liver or kidney disease
- History of substance abuse
- Pregnancy or breastfeeding

DRUG INTERACTIONS: This drug may cause increased side effects when taken with alcohol, muscle relaxants, sedatives, tricyclic antidepressants, MAO inhibitors other pain medicines, other products containing acetaminophen (Tylenol), isoniazid (INH), ritonavir.

WARNINGS:

- Do not drive, ride a bicycle, or operate dangerous equipment while taking this medicine until you know how it will affect you.
- Prolonged use of this medicine can be habit forming and may lead to addiction.

[NOTE: This information topic may not include all directions, precautions, medical conditions, drug/food interactions, and warnings for this drug. Check with your doctor, nurse, or pharmacist for any questions that you may have.]

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

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Misc./Treatment

SLING



A sling is designed to support your arm in a position of rest. It is used for injuries of the hand, forearm, upper arm, and shoulder.

A shoulder that is immobilized too long can become stiff and lose range of motion. Follow up with your doctor as advised and do not use the sling longer than directed.

HOME USE:

1. Leave the sling in place as long as directed by your doctor. Unless told otherwise, you may remove it when bathing, dressing, and when you go to sleep.

The sling is adjustable. If it becomes loose, adjust it so that your forearm is horizontal (level with the ground). Your hand should be level with the elbow.

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DOCUMENT NAME:
SERVICE DATE/TIME:
RESULT STATUS:
PERFORM INFORMATION:
SIGN INFORMATION:

ED Patient Summary
6/6/2015 01:59 EDT
Auth (Verified)
Housley RN, Korle A (6/6/2015 01:59 EDT)
Housley RN, Korle A (6/6/2015 01:59 EDT)

ED Patient Summary

AIKEN REGIONAL MEDICAL CENTER

Confirmation of Receipt of Instructions

Name: WIER, SHAWN A

Print Date/Time 8/28/2015 13:00 EDT

Medical Record

Page 14 of 30

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Age: 27 Years Date of Birth: [REDACTED] 12:00 AM

MRN: AIK341692 FIN: AIK0000116936964 Arrival Time: 6/05/2015 11:22 PM

Diagnosis: Arm pain 729.5; Contusion of the elbow 923.11

Patient Visit Summary:

WIER, SHAWN A has been provided patient education materials, follow-up instructions and prescriptions.

My Signature Below Indicates:

- > I have received and understood the oral instructions regarding my current medical problem.
- > I will arrange follow-up care as instructed, outlined in this and any following page(s).
- > I acknowledge continuing medications prescribed by my regular doctor.
- > I acknowledge receipt of the written instructions as outlined in this and any previous page(s).
- > I will read and review these instructions.
- > I acknowledge that I will contact my Primary Care Physician or return to the Emergency Department immediately if symptoms worsen or persist.

☐ Patient Refuses to Sign

☐ Patient Left Without Signing

☐ Patient was informed of their non-emergent status

Patient Signature

Parent / Guardian (if patient is a minor)

Nurse Signature (if not patient signature)

Hospital Witness Signature (if no patient signature)

NOTE: Permanent Medical Record

AIKEN REGIONAL MEDICAL CENTER
302 University Parkway, Aiken, SC 29801
www.aikenregional.com
(803) 641-5000

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Name: WIER, SHAWN A

Age: 27 Years Date of Birth: [REDACTED] 12:00 AM

MRN: AIK341692 FIN: AIK0000116936964 Arrival Time: 6/05/2015 11:22 PM

Diagnosis: Arm pain 729.5; Contusion of the elbow 923.11

Emergency Department Care Team:

Provider: ED AIK, Staff Physician; Sink PA, Mark H

The Emergency Department physician has reviewed the information that you have provided concerning medications that have been prescribed previously and found there to be no conflict with any therapy recommended by the Emergency Department physicians. Unless instructed by the Emergency Department physician to discontinue specific medications, you should continue medications prescribed by your regular doctor and follow-up with your doctor or with the physician/facility recommended by the ED as appropriate.

If you plan on operating a motor vehicle or using any dangerous equipment within the next several hours, please check with your physician or nurse to make sure that none of the medicines that you received in the Emergency Department could interfere with your performance of these tasks.

The physicians and staff of the Aiken Regional Medical Center encourage you to lead a healthy lifestyle. If you smoke, we strongly urge you to quit. Contact your local American Lung Association for additional information.

Allergies:

No Known Allergies

Vaccination/Immunologic Information**Prescriptions Given to Patient/Caregiver(s):**

Prescription	Display
hydrocodone-acetaminophen (Norco 5 mg-325 mg oral tablet)	2 Tabs, Oral, q4H, PRN for pain, may take 1 to 2 tabs per dose, X 3 Days, # 36 Tabs, 0 Refill(s), Acute, 06/09/15
naproxen (Naprosyn 500 mg oral tablet)	500 mg = 1 Tabs, Oral, BID, PRN as needed for inflammation, # 20 Tabs, 0 Refill(s), Maintenance
Home Meds	Display

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
 MRN: AIK341692
 DOB/Sex: [REDACTED] / Male
 Attending: High MD, Aaron L

Admit: 6/5/2015
 Disch: 6/6/2015
 FIN: AIK0000116936964

Emergency Dept

PARoxetine (Paxil 40 mg
 oral tablet)

1 Tabs, Oral, Daily, # 30 Tabs, 0 Refill(s), Maintenance

Medication Special Considerations:

Patient Education Materials Provided:

CONTUSION, Elbow; ELBOW FRACTURE; SLING; NAPROSYN; HYDROCODONE; ARMC ED Safe Medication Management (Custom)

Comment:

Follow-up Instructions:

With:	Address:	When:
AIK- CMI-Orthopedics	410 University Parkway, Suite 1000 Aiken, SC 29801 8036490563 Business (1)	Within 3-5 days

Comments:

With:	Address:	When:
Dr No pcp no family	000000000	Within 1-2 days

Comments:

CONTUSION, ELBOW

A contusion of your elbow causes local pain, swelling and sometimes bruising. There are no broken bones. This injury takes a few days to a few weeks to heal. A sling may be provided for comfort and arm support

HOME CARE :

1. Keep your arm elevated to reduce pain and swelling. This is most important during the first 48 hours after injury.
2. Apply an ice pack (ice cubes in a plastic bag, wrapped in a towel) over the injured area for 20 minutes every 1-2 hours the first day. You should continue with ice packs 3-4 times a day for the next two days. Continue the use of ice packs for relief of pain and swelling as needed.

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

3. You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another pain medicine was prescribed. [NOTE: If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.]
4. If a sling was provided, you may remove it to shower or bathe. Do not wear it for more than one week or it may cause joint stiffness.

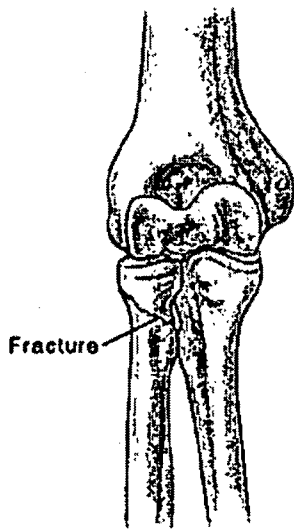
FOLLOW UP with your doctor or as advised by our staff if you are not starting to improve within the next three days.

GET PROMPT MEDICAL ATTENTION if any of the following occur:

- Pain or swelling increases
 - Redness, warmth or drainage
- Hand or fingers becomes cold, blue, numb or tingly

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FRACTURE: ELBOW



You have a break (fracture) of the elbow. This may be a small crack in the bone; or a major break with the broken parts pushed out of position.

This fracture usually takes 4-12 weeks to heal, depending on the type. Initial treatment is with a splint or cast. Severe fractures may require surgery to put the bone fragments back into place.

Print Date/Time 8/28/2015 13:00 EDT

Medical Record

Page 18 of 30

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

HOME CARE:

1. Keep your arm elevated to reduce pain and swelling. When sitting or lying down elevate your arm above the level of your heart. You can do this by placing your arm on a pillow that rests on your chest or on a pillow at your side. This is most important during the first 48 hours after injury.
2. Apply an ice pack (ice cubes in a plastic bag, wrapped in a towel) over the injured area for 20 minutes every 1-2 hours the first day. You can place the ice pack inside the sling and directly over the splint/cast. Continue with ice packs 3-4 times a day for the next two days, then as needed for the relief of pain and swelling.
3. Keep the splint/cast completely dry at all times. Bathe with your splint/cast out of the water, protected with a large plastic bag, rubber-banded at the top end. If a fiberglass splint/cast gets wet, you can dry it with a hair-dryer.
4. You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another pain medicine was prescribed. **[NOTE:** If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.]

FOLLOW UP with your doctor in one week, or as advised by our staff, to be sure the bone is healing properly. If a splint was applied, it will be changed to a cast during your follow-up visit.

[NOTE: A radiologist will review any X-rays that were taken. We will notify you of any new findings that may affect your care.]

GET PROMPT MEDICAL ATTENTION if any of the following occur:

- The plaster cast or splint becomes wet or soft
 - The fiberglass cast or splint remains wet for more than 24 hours
 - Increased tightness or pain under the cast or splint
- Fingers become swollen, cold, blue, numb or tingly

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SLING



AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

A sling is designed to support your arm in a position of rest. It is used for injuries of the hand, forearm, upper arm, and shoulder.

A shoulder that is immobilized too long can become stiff and lose range of motion. Follow up with your doctor as advised and do not use the sling longer than directed.

HOME USE:

1. Leave the sling in place as long as directed by your doctor. Unless told otherwise, you may remove it when bathing, dressing, and when you go to sleep.

The sling is adjustable. If it becomes loose, adjust it so that your forearm is horizontal (level with the ground). Your hand should be level with the elbow.

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MEDICATION: NAPROXEN

Naproxen (brand names: Naprosyn, Anaprox, Aleve, Naprelan, Pamprin, Midol) is an anti-inflammatory drug which is very useful for pain and inflammatory conditions.

DIRECTIONS FOR USE:

You may take this medicine with food to reduce stomach upset.

WHAT TO WATCH FOR:

POSSIBLE SIDE EFFECTS: Nausea, upper abdominal pain, drowsiness, dizziness, ringing in the ears (Contact your doctor if these symptoms persist or become severe). Bleeding from the stomach, which may appear as blood in vomit or stool (red or black color); rapid weight gain, leg swelling or easy bruising, change in the amount of urine, confusion/mood changes, very stiff neck, yellowing of the eyes/skin (Contact your doctor or return to this facility promptly).

ALLERGIC REACTION: Rash, itching, swelling, trouble breathing or swallowing (Contact your doctor or return to this facility promptly).

MEDICAL CONDITIONS: Before starting this medicine, be sure your doctor knows if you have any of the following conditions:

- Stomach ulcer (active or in the past), history of vomiting blood or bloody stools
- Allergic reaction to aspirin or other anti-inflammatory medicines
- Asthma, nasal polyps or angioedema; pregnancy or breastfeeding

Print Date/Time 8/28/2015 13:00 EDT

Medical Record

Page 20 of 30

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

- Liver or kidney disease; bleeding disorder, diabetes

DRUG INTERACTION: Before starting this medicine, be sure your doctor knows if you are taking any of the following drugs:

- Blood thinners [Coumadin (warfarin), low molecular weight heparins, heparin], cyclosporine, diuretics (water pills), blood pressure pills, ACE inhibitors (Lotensin, Capoten, Vasotec, Zestril, and others), diabetes pills, steroids (methylprednisolone, prednisone), aspirin or other anti-inflammatory drugs, methotrexate, probenecid, cidofovir, antiplatelet drugs such as Plavix (clopidogrel), desmopressin, drugs for osteoporosis [Fosamax(alendronate)], lithium, pemetrexed, bile acid binding resins, drotrecogin, SSRI antidepressants (fluoxetine, sertraline)

WARNINGS:

- Do not take with prednisone, other anti-inflammatory drugs, or alcohol since this increases the risk of getting a bleeding ulcer.
- Do not drive, ride a bicycle, or operate dangerous equipment while taking this medicine until you know how it will affect you.

[NOTE: This information topic may not include all directions, precautions, medical conditions, drug/food interactions, and warnings for this drug. Check with your doctor, nurse, or pharmacist for any questions that you may have.]

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MEDICATION: HYDROCODONE + ACETAMINOPHEN

Hydrocodone/acetaminophen (brand names: Vicodin, LorTab, Anexsia, Norco) is a narcotic pain medicine. This medicine contains Tylenol (acetaminophen).

DIRECTIONS FOR USE:

If this medicine upsets your stomach, take it with food or milk. Pain medication should be taken only if needed at the times prescribed. If you are not having pain, do not take the medicine unless you are advised to do so by your doctor.

Do not take more than 4 grams (4,000 mg) of acetaminophen (Tylenol) per 24 hours.

WHAT TO WATCH FOR:

POSSIBLE SIDE EFFECTS: Dizziness, drowsiness (Take a smaller dose; for example, break the pill in half or take it less often). Constipation (Drink lots of liquids, use small doses of a mild laxative like milk of magnesia, as needed). Nausea, vomiting (Take with food or milk). Difficulty passing urine (Stop the medicine and contact your doctor).

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

ALLERGIC REACTION: Rash, itching, swelling, trouble breathing or swallowing (Contact your doctor or return to this facility promptly).

MEDICAL CONDITIONS: Before starting this medicine, be sure your doctor knows if you have any of the following conditions:

- Prostate enlargement
- Lung disease (asthma, COPD)
- Allergy to aspirin or other salicylates
- Intestinal obstruction or severe constipation
- Liver or kidney disease
- History of substance abuse
- Pregnancy or breastfeeding

DRUG INTERACTIONS: This drug may cause increased side effects when taken with alcohol, muscle relaxants, sedatives, tricyclic antidepressants, MAO inhibitors other pain medicines, other products containing acetaminophen (Tylenol), isoniazid (INH), ritonavir.

WARNINGS:

- Do not drive, ride a bicycle, or operate dangerous equipment while taking this medicine until you know how it will affect you.
- Prolonged use of this medicine can be habit forming and may lead to addiction.

[NOTE: This information topic may not include all directions, precautions, medical conditions, drug/food interactions, and warnings for this drug. Check with your doctor, nurse, or pharmacist for any questions that you may have.]

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SPECIAL INSTRUCTIONS FOR HANDLING YOUR MEDICATIONS

It is very important to take your medications as directed. In addition, you should provide a list of your medications to your primary care Physician. Your medication list should be updated when medications are changed or discontinued and when new medications are added (including over the counter medications). Carry your medication list with you at all times as this can provide very valuable information in the event you are involved in an emergency situation.

Please be sure to bring your medication list with you anytime you visit the Emergency Department.

FOLLOW UP with your doctor or as advised by our staff. If you do not have your own doctor, we can recommend one for you.

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

To find additional information about the medications you are taking, you can visit the following website - ConsumerMedSafety.org.

Major Tests and Procedures:

The following procedures and tests were performed during your ED visit.

Splint Application

Laboratory Orders

No laboratory orders were placed.

Radiology Orders

Name	Status	Details
XR Elbow	Ordered	06/06/15 0:33:00 EDT, Stat, Reason: Pain in Joint, Elbow/Upper Arm.
Complete Left		Transport Mode: Stretcher, 175 cm, 90.72

Cardiology Orders

No cardiology orders were placed.

DOCUMENT NAME:
SERVICE DATE/TIME:
RESULT STATUS:
PERFORM INFORMATION:
SIGN INFORMATION:

ED Clinical Summary
6/6/2015 01:59 EDT
Auth (Verified)
Housley RN, Korie A (6/6/2015 01:59 EDT)
Housley RN, Korie A (6/6/2015 01:59 EDT)

ED Clinical Summary

AIK- Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801
<http://www.aikenregional.com/>
(803) 641-5000

SUMMARY OF CARE

This document contains **CONFIDENTIAL** health information that is legally privileged. Please be sure to take this document to your follow-up appointment so that your provider has access to the necessary information about your recent hospitalization.

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Patient Information:

Name: WIER, SHAWN A	Age: 27 Years	DOB: [REDACTED] 12:00 AM
Sex: Male	Language: ENG-English	PCP: No pcp no family, Dr MD
MRN: AIK341692	FIN: AIK0000116936964	FC:
Arrival Date: 6/05/2015 11:22 PM	Disposition: ED Home, Routine	Discharge: 6/06/2015 1:59 AM
Diagnosis: Arm pain 729.5;		ED Depart Time:
Contusion of the elbow 923.11		6/06/2015 1:59 AM

Visit Summary For SHAWN WIER

We would like to thank you for allowing us to assist you with your healthcare needs. Our entire staff strives to provide an excellent experience for our patients and their families. The following includes information regarding your visit.

Age: 27 years Sex: Male DOB: [REDACTED] MRN: 341692
Address: 2017 HONORS CIR GRANITEVILLE, SC 298294089
Home: 7578673938 Work: -- Mobile: --
Primary Care Provider: No pcp no family, Dr MD
Race: White Ethnicity: Non-Hispanic
Language: ENG-English
Health Plan: --

Problems

No Problems Documented

Follow Up

With:	Address:	When:
AIK- CMI-Orthopedics	410 University Parkway, Suite 1000 Aiken, SC 29801 8036490563 Business (1)	Within 3-5 days

Comments:

With:	Address:	When:
Dr No pcp no family	000000000	Within 1-2 days

Comments:

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Care Team

Attending: ED AIK, Staff Physician

Admitting: ED AIK, Staff Physician

Consulting:

Allergies

No Known Allergies

Medical Information

Prescriptions Given to Patient/Caregiver(s):

Fill New Prescriptions:

hydrocodone-acetaminophen (Norco 5 mg-325 mg oral tablet) 2 Tabs By Mouth Every 4 hours scheduled 3 Days as needed for for pain may take 1 to 2 tabs per dose
naproxen (Naprosyn 500 mg oral tablet) 500 mg By Mouth 2 Times a Day as needed for as needed for inflammation

Home Medications per Patient/Caregiver(s):

Home Meds

PARoxetine (Paxil 40 mg oral tablet), 1 Tabs, By Mouth, Daily

Smoking Status

Functional Status

Mode of Discharge: Ambulates without assistance

Home Equipment:

Level of Consciousness:

Affect/Behavior:

Activities of Daily Living:

Care Plan

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Patient Education Information:

Instructions Provided:

CONTUSION, Elbow; ELBOW FRACTURE; SLING; NAPROSYN; HYDROCODONE; ARMC ED Safe Medication Management (Custom)

Physician Documentation / Notes:

Patient: WIER, SHAWN A MRN: AIK341692 FIN: AIK0000116936964
Age: 27 years Sex: Male DOB: [REDACTED]
Associated Diagnoses: None
Author: Sink PA, Mark H

Basic Information

Time seen: Date & time 6/6/2015 00:27:00, Provider Assignment
Sink PA, Mark H assigned at 06/06/2015 00:27

History source: Patient

Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint
6/5/2015 23:23 EDT Chief Complaint c/o lt elbow pain. when picking item up at work tonight hit lt elbow on "hard piece of plastic"

History of Present Illness

The patient presents with left, arm injury. The onset was 6 hours ago. The course/duration of symptoms is constant. Type of injury: direct blow. The location where the incident occurred was at work. Location: Left posterior lateral elbow. The character of symptoms is pain and swelling. The degree of pain is moderate. The degree of swelling is minimal. There are exacerbating factors including activity, movement and palpation. The relieving factor is immobilization. Risk factors consist of none. The patient's dominant hand is the right hand. Prior episodes: none. Therapy today: none. Associated symptoms: none. Additional history: notes that he was lifting up something at work and hit his elbow really hard.

Review of Systems

Constitutional symptoms: Negative except as documented in HPI.
Skin symptoms: Negative except as documented in HPI.
Eye symptoms: Negative except as documented in HPI.
ENMT symptoms: Negative except as documented in HPI.
Respiratory symptoms: Negative except as documented in HPI.
Cardiovascular symptoms: Negative except as documented in HPI.
Gastrointestinal symptoms: Negative except as documented in HPI.
Genitourinary symptoms: Negative except as documented in HPI.
Musculoskeletal symptoms: Joint pain.
Neurologic symptoms: Negative except as documented in HPI.
Psychiatric symptoms: Negative except as documented in HPI.
Endocrine symptoms: Negative except as documented in HPI.
Hematologic/Lymphatic symptoms: Negative except as documented in HPI.
Allergy/immunologic symptoms: Negative except as documented in HPI.
Additional review of systems information: All other systems reviewed and otherwise negative.

Health Status

Allergies:

Allergic Reactions (All)

No Known Allergies.

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Past Medical/ Family/ Social History

Surgical history:

No active procedure history items have been selected or recorded..

Family history:

No family history items have been selected or recorded..

Physical Examination

Vital Signs

Vital Signs (ST)

<u>Vital Signs (24 hrs)</u>	<u>Last Charted</u>	<u>Minimum</u>	<u>Maximum</u>
Temp	36.8 (JUN 05 23:23)	36.8 (JUN 05 23:23)	36.8 (JUN 05 23:23)
Peripheral Pulse Rate	L 58 (JUN 05 23:23)	L 58 (JUN 05 23:23)	L 58 (JUN 05 23:23)
Resp Rate	16 (JUN 05 23:23)	16 (JUN 05 23:23)	16 (JUN 05 23:23)
SBP	129 (JUN 05 23:23)	129 (JUN 05 23:23)	129 (JUN 05 23:23)
DBP	73 (JUN 05 23:23)	73 (JUN 05 23:23)	73 (JUN 05 23:23)
SpO2	99 (JUN 05 23:23)	99 (JUN 05 23:23)	99 (JUN 05 23:23)
	Room air	Room air	Room air

Per nurse's notes.

Oxygen saturation.

General: Alert, no acute distress.

Skin: Warm, dry, pink, intact.

Head: Normocephalic.

Neck: Trachea midline.

Eye: Pupils are equal, round and reactive to light.

Cardiovascular: Normal peripheral perfusion, No edema.

Respiratory: Respirations are non-labored.

Chest wall: No tenderness, No deformity.

Musculoskeletal: Normal ROM, Proximal upper extremity: Left, posterior, lateral, elbow, olecranon, tenderness, range of motion (limited, active, passive, on extension, restricted by pain).

Gastrointestinal: Soft, Nontender, Non distended.

Neurological: Alert and oriented to person, place, time, and situation, No focal neurological deficit observed, CN II-XII intact, normal sensory observed, normal motor observed, normal speech observed.

Lymphatics: No lymphadenopathy.

Psychiatric: Cooperative, appropriate mood & affect.

Medical Decision Making

Differential Diagnosis: Fracture, sprain, strain, contusion.

Orders Launch Orders

Patient Care:

Sling (Order): 6/6/2015 1:34 EDT, Routine, Left

Splint Forearm - Sugar Tong (Order): 6/6/2015 1:34 EDT, Routine, Left, Review/Insert Order Profile (Selected).

Inpatient Orders

Ordered (Exam Ordered)

XR Elbow Complete Left.

Elbow x-ray findings Normal alignment, no fracture, interpretation by Emergency Physician, Anterior fat pad sign without obvious fracture.

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWNA
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Emergency Dept

Impression and Plan

Diagnosis

Arm pain 729.5 - ICD9 729.5,
Contusion of the elbow 923.11 - ICD9 923.11,

Plan

Condition: Improved, Stable.

Prescriptions: Launch PrescriptionWriter

Pharmacy:

Naprosyn 500 mg oral tablet (Prescribe): 500 mg, 1 Tabs, Oral, BID, 20 Tabs, PRN, as needed for inflammation
Norco 5 mg-325 mg oral tablet (Prescribe): 2 Tabs, Oral, q4H, may take 1 to 2 tabs per dose, 36 Tabs, PRN, for pain
Work Restrictions: Left Arm (Prescribe): 1 Each, Misc, Once, Please allow patient to work with sling and no use of left arm until orthopedic clearance., 1 Each.

Patient was given the following educational materials: CONTUSION, Elbow, ELBOW FRACTURE, SLING.

Limitations: Limited activity, Limited work.

Follow up with: Dr No pop no family Within 1-2 days; AIK- CMI-Orthopedics Within 3-5 days.

Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Regarding prescription, Patient indicated understanding of instructions.

Disposition: Launch Disposition Order

Admit/Transfer/Discharge:

Discharge Request (Order): 6/6/2015 1:36 EDT, Home Routine.

Assessment Forms

DOCUMENT TYPE:	ED Vital Signs and Pain - Text
SERVICE DATE/TIME:	6/6/2015 01:58 EDT
RESULT STATUS:	Auth (Verified)
PERFORMED INFORMATION:	Housley RN, Korie A (6/6/2015 01:58 EDT)
SIGNED INFORMATION:	Housley RN, Korie A (6/6/2015 01:58 EDT)

ED Reassess / Vital Signs and Pain Adult Entered On: 6/6/2015 1:59 EDT
Performed On: 6/6/2015 1:58 EDT by Housley RN, Korie A

Vitals/Ht/Wt

Systolic Blood Pressure : 129 mmHg
Diastolic Blood Pressure : 73 mmHg

Housley RN, Korie A - 6/6/2015 1:58 EDT

Primary Pain

Numeric Rating : 5 = Moderate pain

Housley RN, Korie A - 6/6/2015 1:58 EDT

Discharge Care Plan

Mode of Discharge : Ambulates without assistance
Discharge Transportation : Cab
Accompanied By : Alone
Transfer Notification Request : No

Housley RN, Korie A - 6/6/2015 1:58 EDT

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Orders - Medications (Brief)

Documented medications

Order: PARoxetine (Paxil 40 mg oral tablet)
Order Date/Time: 6/6/2015 01:37 EDT
Signed Date/Time: 6/6/2015 01:37 EDT
Order Status: Documented Clinical Category: Medications Medication Type: Documented
Ordering Physician: Consulting Physician:
Entered By: Housley RN, Korie A on 6/6/2015 01:37 EDT
Order Details: 1 Tabs, Oral, Daily, # 30 Tabs, 0 Refill(s), Maintenance
Order Comment:

Prescription

Order: hydrocodone-acetaminophen (Norco 5 mg-325 mg oral tablet)
Order Date/Time: 6/6/2015 01:34 EDT
Signed Date/Time: 6/6/2015 01:34 EDT
Order Status: Completed Clinical Category: Medications Medication Type: Prescription
End-state Date/Time: 6/9/2015 01:34 EDT End-state Reason:
Ordering Physician: Sink PA, Mark H Consulting Physician:
Entered By: SYSTEM on 6/9/2015 01:47 EDT
Order Details: 2 Tabs, Oral, q4H, PRN for pain, may take 1 to 2 tabs per dose, X 3 Days, # 36 Tabs, 0 Refill(s), Acute, 06/09/15
Order Comment:

Order: naproxen (Naprosyn 500 mg oral tablet)
Order Date/Time: 6/6/2015 01:34 EDT
Signed Date/Time: 6/6/2015 01:34 EDT
Order Status: Prescribed Clinical Category: Medications Medication Type: Prescription
Ordering Physician: Sink PA, Mark H Consulting Physician:
Entered By: Sink PA, Mark H on 6/6/2015 01:35 EDT
Order Details: 500 mg = 1 Tabs, Oral, BID, PRN as needed for inflammation, # 20 Tabs, 0 Refill(s), Maintenance
Order Comment:

Order: Orders (Work Restrictions: Left Arm)
Order Date/Time: 6/6/2015 01:34 EDT
Signed Date/Time: 6/6/2015 01:34 EDT
Order Status: Completed Clinical Category: Medications Medication Type: Prescription
End-state Date/Time: 6/6/2015 01:34 EDT End-state Reason:
Ordering Physician: Sink PA, Mark H Consulting Physician:
Entered By: Sink PA, Mark H on 6/6/2015 01:35 EDT
Order Details: Work Restrictions: Left Arm, Please allow patient to work with sling and no use of left arm until orthopedic clearance.
Order Comment:

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Imaging

PROCEDURE
XR Elbow Complete Left

EXAM DATE/TIME
6/6/2015 00:43 EDT

Report

Left Elbow

Indication: Elbow pain.

Technique: Three views of the left elbow without prior films.

Findings: The bony mineralization is normal. No fracture or dislocation. Radial head is intact. No posterior humeral fat pad visualized. Soft tissues are unremarkable. No advanced osteoarthritic degenerative changes.

Impression:

1. Intact left elbow.
2. No fracture or dislocation.

Dictated By: ANTHONY TOOMER, MD
DID 45443

D:/T:pt/12622067 /Job ID 13639450 /DT:06/06/2015 08:50:56/TD:06/06/2015 12:43:14 /Rev:
06/06/2015 12:43:14
cc:

This document was electronically signed by ANTHONY TOOMER, MD on
06/06/2015 18:15:46 .

***** Final *****

Dictated by: Toomer, Anthony MD
Transcribed By: AT
Electronically Signed by: Toomer, Anthony MD

Dictated DT/TM: 06/06/2015 8:50 am
Transcribed DT/TM: 06/06/15 12:43:00
Signed DT/TM: 06/06/2015 6:15 pm

AIK- Aiken Regional Medical Centers
302 University Parkway
Aiken, SC 29801-6302

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: [REDACTED] / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015 Disch Time: 01:59 EDT
FIN: AIK0000116936964

Allergies

Substance	Allergy Type	Reaction Symptom	Reviewed Date/Time	Reaction Status
No Known Allergies	Allergy		6/6/2015 00:46 EDT	Active

Facesheets

SERVICE DATE/TIME:
RESULT STATUS:
PERFORM INFORMATION:
SIGN INFORMATION:

Facesheets
6/5/2015 00:00 EDT
In Progress

AIK- Aiken Regional Medical Centers

Patient: WIER, SHAWN A
MRN: AIK341692
DOB/Sex: / Male
Attending: High MD, Aaron L

Admit: 6/5/2015
Disch: 6/6/2015
FIN: AIK0000116936964

Facesheets

Attachment(s):
6/5/2015 00:00 EDT FACE SHEET REGISTRATION FORM_20150605.pdf

ABMC-WIER, SHAWN A-ENC 1116936964-0PT-ENR-6/5/2015 FACE SHEET REGISTRATION FORM - 6/5/2015 - 1 pg

ENC 0001 341692

116936964		WIER, SHAWN A	
2017 HONORS CIR		STATE SC	ZIP 298294089
GRANITEVILLE		PHONE (757) 867-3938	PATIENT LANGUAGE ENGLISH
27 Y	SEX M	HAIR B	HEIGHT 5'11"
PO BOX 2878	TELEPHONE (803) 863-1147	CITY Aiken	OCCUPATION PRODUCTION
288 WAGENER RD PO BOX 2878		STATE SC	ZIP 298294089
Aiken		REGISTRATION DATE	6/5/2015
Contact Information			
2017 HONORS CIR		STATE SC	ZIP 298294089
GRANITEVILLE		PHONE (757) 867-3938	
2017 HONORS CIR		STATE SC	ZIP 298294089
GRANITEVILLE		PHONE (757) 867-3938	
Guardian Information			
WIER, SHAWN A		STATE SC	ZIP 298294089
2017 HONORS CIR SUITE 204		PHONE (757) 867-3938	
GRANITEVILLE		STATE SC	ZIP 298294089
288 WAGENER RD PO BOX 2878		TELEPHONE (803) 863-1147	
Aiken		STATE SC	ZIP 298294089
Insurance Information			
WORKERS COMP OP		STATE SC	ZIP 298294089
PO BOX 2878		STATE SC	ZIP 298294089
WIER, SHAWN A		STATE SC	ZIP 298294089
GRANITEVILLE		PHONE (757) 867-3938	
2017 HONORS CIR		STATE SC	ZIP 298294089
GRANITEVILLE		PHONE (757) 867-3938	
Admitting Information			
06/05/2015		TIME 1700	ORGANIZATION
SINK MARK		ATTENDING	ADMITTING
LY ELBOWPAIN		EMR	POV PRIVATE VEHICLE
SUBJ: 1692		ADMITTING	ADMITTING
NO REFERRING DOCTOR		ADMITTING	ADMITTING

Aiken Regional Medical Centers
302 University Pkwy
PO Drawer 1117
Aiken, SC 29801



EL0012

Page 1 of 1

MEDICAL
RECORD

LHS-0022
Rev 6/1/13

Patient Identification



WIER, SHAWN A
DOB: 6/5/2015 27 Y SX: M ENR
MRN: 341692 ADM/REG DT: 06/05/2015
Aiken Regional Medical Centers

FACE SHEET REGISTRATION FORM_20150605.pdf
Please click on link to see image.

Print Date/Time 8/28/2015 13:00 EDT

Medical Record

Page 2 of 30

Consult Note - MOORE ORTHOPAEDIC CLINIC for WIER, SHAWN [REDACTED] (28yo M) #11081 E#11081

To: Page 3 of 11

2015-11-24 14:29:32 (GMT)

From: Chris Black

Re: Shawn Wier
DOB: [REDACTED]
Chart No: 379189

SSN: [REDACTED]

I saw Shawn Wier on July 6, 2015. Mr. Wier gave me a history of having injured his left elbow at work when hit his elbow on a piece of equipment. I have diagnosed him with lateral epicondylitis. It is my opinion within a reasonable degree of medical certainty that Mr. Wier's elbow problems were most probably caused by this incident at work occurring on June 5, 2015.

☒

I agree with the above statement.

☐

I do not agree with the above statement.


Mickey Plymate, MDDated: 12.2.15



G4S Secure Solutions (USA) Inc.
1370 Browning Road Ste 110
Columbia, SC 29210

Telephone: 803 256 7080
Fax: 803 256 0768
Email: Jamie.proctor@usa.g4s.com
www.g4s.com/us

September 29, 2015

Huff Law Firm LLC
Attention: E. Ros Huff, Jr.
7244 Woodrow Street
Irmo, SC 29063

Re: Response to Request pertaining to Shawn Wier

Mr. Huff:

Please find the attached personnel file of Shawn Wier. We are sending this in response to the subpoena received 9/18/15.

Please let us know if we can be of any more assistance in this matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jamie Proctor', written in a cursive style.

Jamie Proctor, Office Manager

PERSONNEL ACTION CHANGE

Prepared by: Laquica Lewis

Action Effective Date: 01 22 2015
Month Day Year

Last Name Wier First Name Shawn
Employer G 4 S Business Unit 0 0 0 0 1 Department C O L - 8
Social Security # (Last Four Digits)

SALARY CHANGE

Last Review Date _____ Next Review Date _____
 Month Day Year Month Day Year
 SC Reason _____ New Base Rate \$ _____ Base Frequency _____ (A)nnual (H)ourly
 Merit _____ % Adjustment _____ % Promotion _____ % Total _____ % Billable _____ (Y)es (N)o
 New Title _____
 Current Salary/Rate \$ _____ Last Increase/Decrease _____ % Effective Date _____
 Month Day Year
 No pay increase/decrease may be processed without being supported by a Career Development Review. See policy POL-0621 for more details.

TRANSFER/NEW TITLE

TR Reason _____ TR to Employer _____ Business Unit _____ Department _____
Position _____ Scheduled Pay Periods 28/527 Regular hrs/per period _____
Title _____

STATUS CHANGE

Status _____ Leave Code _____

Month _____ Day _____ Year _____

Month _____ Day _____ Year _____

TERMINATIONS

Was full time work available?	Yes ☒	No ☐	Not Applicable
Did employee refuse work?	☐	☒	
Licensing agency notified of termination?	☐	☐	☒
Length of notice (number of days)?	1 4		

Termination	V	0	1	Status	A	H	F	R
Last day worked	0	1	2	1	2	0	1	5
	Month		Day		Year			

Provide pertinent details documenting the termination in the comments section below and on form FM-232 Employee Termination Questionnaire. If one of the termination reasons does not accurately describe the termination, please explain in "comments" area.

PERSONAL CHANGES

Last Name _____ First Name _____
 Address _____
 City/Town _____ State/Province _____ Zip Code _____
 Country _____ County _____ Marital Status _____
 Home Phone _____ Cell Phone _____

EMERGENCY CONTACT

Last Name _____ First Name _____
 Address _____ Relationship _____
 City/Town _____ State/Province _____ Zip Code _____
 Home Phone _____ Cell/Work Phone _____

COMMENTS Officer Wier resigned due to other employment.

APPROVALS

Branch/Facility	Date	Payroll	Date
Other Headquarters	Date	Human Resources	Date



SECURITY OFFICER REPORT

FM-008 (11/28/06) 74100

SIGNED

Page 1 of 1



Uniform and Accessories Record

Employee Name

Shawn Wier

Date 3 Dec 14

Social Security Number (Last 4 Digits Only)

5408

Office / Location

COL/AGY

Item	Size	Number Issued	Date Issued	Employee's Initials	Number Returned	Date Returned	Employee's Initials
Headgear: Stetson ☐ Winter ☐							
Ball Cap ☐ Other ☐							
Headgear: Rain Cover							
Shirt, L.S. PRO ☐ CPO ☐							
TSO/USO ☐ Other ☐							
Shirt, S.S. PRO ☐ CPO ☐							
TSO/USO ☒ Other ☐	X-Lg	2	12-3-14	SW			
Tie Long ☐							
Crossover ☐							
Trousers PRO ☐ CPO ☐							
TSO/USO ☒ Other ☐	40	1	12-3-14	SW			
Blazer PRO ☐							
Other ☐							
Coat Windbreaker ☐ WB with Liner ☐							
Parka ☐ Other ☒	X-Lg	1	12-3-14	SW			
Vest ☐							
Sweater Cardigan ☐							
Raincoat GPC Tan ☐							
Yellow ☐							
Belt with Buckle (Regular) Silver ☐							
Gold ☐							
Breast Badge 90401 Silver ☒		1	12-3-14	SW			
Gold ☐							
Whistle, Chain & Hook Silver ☒		1	12-3-14	SW			
Gold ☐							
Snap Belt							
Gun Belt							
Belt Keepers							
Holster							
Speed Loader ☐							
Magazine ☐							
Weapon Locking Cable							
Security Officer Handbook		1	12-1-14	SW			
ID Card No. _____							
Safety Handbook		1	12-1-14	SW			

I hereby acknowledge receipt of the items of equipment and/or clothing above initiated by me and I hereby acknowledge that those items are and shall remain the property of G4S Secure Solutions (USA) Inc. (hereinafter referred to as "G4S"). At the termination of my employment with G4S, be it voluntary or involuntary, I agree to return said equipment and/or clothing to G4S. If for any reason I fail to return said items, in good and clean condition, I hereby authorize the G4S to deduct the cost of replacing said items from my last paycheck. I will not carry personally owned weapons either on duty or when traveling in uniform to and from my job. I understand that violation of this policy will be grounds for dismissal.

Supervisor Signature

Employee Signature



NEW HIRE FORM

THIS FORM IS TO BE FILLED OUT BY EMPLOYEE AT TIME OF HIRE.

Social Security # (Last 4 digits) 5408

Office Use Only	New Hire ☒ H Rehire ☐ R Employer <u>G4S</u> Business Unit <u>00001</u> Dept. <u>001-B</u>
	Hire/Rehire Date <u>12 01 2014</u> Adj. Date of Hire _____ Month Day Year Month Day Year
	Position Code <u>00171</u> Title: <u>USD</u>
	Applicant ID Number _____ Requisition Number <u>0470</u>

Last Name Wier
First Name Shawn
Address 1 7234 Roundstone Drive
Address 2 _____
City Graniteville
State/Prov South Carolina Zip Code: 29829
Home Phone 757 867-3938 Date of Birth _____
Area Code Month Day Year
Marital Status M (M-Married, S-Single, W-Widowed, D-Divorced, P-Separated, O-Other) Gender M (F-Female, M-Male)
US Citizen Y (Y-Yes, N-No)

Emergency Contact Information

Contact Name Amanda Wier
Address above
City _____ State _____ Zip Code _____
Contact Tel. No. 785 209-4965 Relationship Wife
Area Code

Office Use Only	Status <u>AHER</u> Billable <u>Y</u> (Y-Yes, N-No)
	No. Pay Periods <u>26</u> (26/52) Pay Rate (Annual/Hourly) <u>10.00</u>
	Reg. Hrs/Pay Period <u>00</u> (xx/40/80) Base Frequency <u>H</u> (A - Annual, H - Hourly)
	Check Seq Code <u>00101</u> Next Review Date _____ Month Day Year

Tax Authorizations

Fed. Filing Status <u>M</u> (M-Married, S-Single)	State Filing Status <u>M</u> (M-Married, S-Single)
Fed. Exemptions <u>06</u> Addtl Fed Amt _____	State Exemptions <u>06</u>
City Exemptions _____ Addtl State Amt _____	County Exemptions _____
Local Exemptions _____	School District Exemptions _____

G4S Secure Solutions (USA) Inc. is a Government contractor and subject to Executive Order 11246, as amended, Section 503 of the Rehabilitation Act of 1973, as amended, and the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended. To meet Government reporting regulations, we ask that you respond to the items below. This information will be used solely for Government reporting purposes. It will not be used when making personnel decisions and will be treated as personal and confidential. Provision of any of this information is voluntary and refusal to provide it will not subject you to adverse treatment.

Ethnic ID D (0-White, 1-Black or African American, 2-Asian, 3-American Indian/Alaskan Native, 4-Hispanic or Latino, 7-Native Hawaiian or Other Pacific Islander, 8-Two or More Races/Not Hispanic or Latino)
Veteran R (1-Non-Veteran, 4-Active Wartime/Campaign Badge Veteran, C-Other Protected Veteran/Chose Not to Identify, D-Disabled Veteran, M-Armed Forces Service Medal Veteran, R-Recently Separated Veteran, O-Other US Military/Non-Covered Veteran)

Military Data

Military Branch US Army Discharge Date 09 14 2014
Month Day Year
Military Occupation 88m Heavy Vehicle operator

Education

High School Ocean Lakes
College/University: _____
School _____
Degree _____ Year _____
Major _____ Minor _____

Driver's License No. _____ Expires 11 06 2018
State _____ Month Day Year

Licenses and Certifications (Check all that apply)

Write in any licenses or clearances not listed.

- | | | |
|---|---|--|
| ☐ 10001 Armed Guard | ☐ 10013 Paramedic | ☐ 10026 Certified Internal Auditor |
| ☐ 10002 Concealed Weapons Permit | ☐ 10015 Professional Engineer | ☐ 10027 Certified Mgt. Analyst |
| ☐ 10003 CPA | ☐ 10016 Real Estate | ☐ 10028 Firearms Instructor I (DOE) |
| ☐ 10004 CPP | ☐ 10017 Registered Nurse | ☐ 10029 Firearms Instructor II |
| ☐ 10005 Emergency Medical Tech. | ☐ 10018 Security | ☐ (DOE) 10030 Instructor (DOE |
| ☐ 10006 Emergency Trauma Tech. | ☐ 10019 Teacher Certification | ☐ Cert.) 10032 Personal Prot Prof |
| ☐ 10007 Firearms | ☐ 10020 Unarmed Guard | ☐ (PPP) 10033 Qual Improv PGM |
| ☐ 10008 Investigations | ☐ 10021 ANSI 13.1 Qual Rad Prot Tech. | ☐ (QIP) 10034 Supervision (DOE) |
| ☐ 10009 Law | ☐ 10022 ANSI 18.1 Qual Rad Prot Tech. | ☐ 10035 Certified Corr. Officer |
| ☐ 10010 LPN | ☐ 10023 Certified Health Physicist | ☐ 10036 Certified Corr. Probation Officer |
| ☐ 10011 Locksmith | ☐ 10024 Natl Reg of Rad Prot Tech | ☐ 10037 Certified Law Enforcement Officer |
| ☐ 10012 Notary | ☐ 10025 Cert Info Science Auditor (CISA) | ☐ 99999 No License |

Clearances (Check all that apply)

- | | | |
|--|--|--|
| ☐ 20001 DOD Confidential | ☐ 20003 DOD Top Secret | ☐ 20005 DOE "L" Clearance |
| ☒ 20002 DOD Secret | ☐ 20004 DOE "Q" Clearance | ☐ 99999 No Clearance |

Approvals

[Signature] 12/1/14
Branch/Facility Date

Corporate Human Resources Date

Other Headquarters Date

Other Date

Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$168,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u>1</u>
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.	B	<u>1</u>
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u>1</u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u>4</u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u>1</u>
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	<u>0</u>
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 \$85,000 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children. • If your total income will be between \$85,000 and \$84,000 (\$95,000 and \$118,000 if married), enter "1" for each eligible child	G	<u>0</u>
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	<u>8</u>

For accuracy, complete all worksheets that apply.

- 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 married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate ▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		OMB No. 1545-0074 2014
1 Your first name and middle initial <u>Shawn A.</u>		Last name <u>Wier</u>		2 Your social security number
Home address (number and street or rural route) <u>7234 Roundstone Drive</u> City or town, state, and ZIP code <u>Graniteville SC, 29829</u>		3 ☐ Single ☒ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		6 Additional amount, if any, you want withheld from each paycheck		7 I claim exemption from withholding for 2014, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had 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 ▶ <u>7</u>
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)

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

Employee's signature (This form is not valid unless you sign it.) ▶ [Signature] Date ▶ 12-1-14

Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income, tax credits, or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$160,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	1
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.	B	1
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	1
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	6
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	1
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
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 (\$95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child	G	2
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	12

For accuracy, complete all worksheets that apply.

- 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 married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate ▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		OMB No. 1545-0074 2014
1 Your first name and middle initial <u>Shawn A.</u>		Last name <u>Wier</u>		2 Your social security number
Home address (number and street or rural route) <u>7234 Roundstone Drive</u>		3 ☐ Single ☒ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code <u>Glanville SC, 29829</u>		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		6 Additional amount, if any, you want withheld from each paycheck		7 I claim exemption from withholding for 2014, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had 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. ▶ <u>7</u>
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.		Employee's signature (This form is not valid unless you sign it.) ▶ <u>[Signature]</u>		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)



Email Provision Option Form

In a continuing effort to enhance communication at G4S Secure Solutions (USA) Inc., G4S' employees who do not have a company e-mail address now have the option of receiving information pertaining to benefits, training, safety, and other company news via their personal e-mail accounts! Providing your personal e-mail address is voluntary. Please select one of the options below:

- ☒ Yes, I want to receive periodic emails from G4S that contain great information about benefits, training, safety, and other company news.

I understand and agree that providing my personal e-mail address for this purpose is purely voluntary and that I will receive no pay for the time I spend reading these e-mails or attachments, which I can delete or read at will. Further, I understand that reading these materials is for my own enlightenment, and I understand that there is no guarantee that a promotion or other workplace benefit will result from it. I also understand that I can opt out of this program at any time by resubmitting a signed copy of this form to my local Human Resources representative.

E-mail address:

Shawn Wier@gmail.com
(Example: anyuser@example.com)

- ☐ No, I do not wish to receive or to continue to receive e-mails from G4S Secure Solutions (USA) Inc.

Shawn A. Wier
Employee Name

12-01-2014
Date

LOC 01
Area/Branch/Project Office


Signature

Instructions to local office: Retain a copy of this form in the individual's personnel file. Enter or delete e-mail address, as appropriate, in PeopleSoft.



The G4S Ethics Code

G4S has a core set of values which are fundamental to the organisation's development and success. One of these values is Integrity which means that we can always be trusted to do the right thing. The Ethics Code below, which forms part of the Group's wider Business Ethics Policy, sets out how we expect all our employees to behave in order to live this core value.

Being honest and fair	Being honest and fair	Being fair and considerate	Being professional and proud
• Putting health & safety first • Protecting the security of our customers, the public and those in our care • Carefully following company rules and procedures	• Always following the law • Reporting any wrongdoing • Never offering or taking a bribe • Avoiding any conflict of interest	• Showing respect and consideration for others • Treating people fairly • Considering our local communities • Thinking about the environment	• Doing the best job you can • Looking smart and professional • Being a good role model • Safeguarding the G4S name

G4S is committed to high ethical standards to maintain the integrity of our organisation, which means that:

- We are completely opposed to bribery and corruption in any form
- No employee can accept money, gifts or inducements from others trying to influence them to perform their work improperly
- No employee can offer money, gifts or inducements in order to persuade others to act improperly, whether for the advantage of G4S or the employee concerned
- No employee can offer money, gifts or inducements to public officials to persuade them to perform their functions more quickly or at all – unless such payments are permitted or required by written law.

Any breaches of these requirements could result in disciplinary action, including immediate dismissal.

Employees must report any wrongdoing that breaches the G4S Ethics Code to their manager through the company's or region's confidential hotline. Managers or supervisors who receive such a report from an employee must contact the Chief Compliance Officer or the hotline. If the wrongdoing relates to a very serious or sensitive matter which cannot be dealt with at country or regional level, contact the Group's confidential hotline telephone number so that an appropriate investigation can be carried out.

I confirm that I have read and understood the G4S Ethics Code.

Shawn A Wier

Employee Name

[Signature]

Employee Signature

Secure Solutions USA

G4S Company/Country

12-01-2014

Date



Consolidated Acknowledgement and Consent

Instructions: The Consolidated Acknowledgement and Consent Form is to be signed upon hire and in December of each year by employees as designated below. For field employees whose personnel files are maintained at Corporate Headquarters, the original signed forms are to be sent to Corporate Human Resources for retention by January 15th of each year. In all other cases, the form is to be filed in the employee's personnel file. Only applicable portions of this form, entering "N/A" where appropriate. Policies and forms referenced herein can be reviewed any time by visiting your local office or by logging onto www.g4s.com.

Policy Title and Number	Statement of Acknowledgement and Consent	Employee Required
POL-0726 Business Ethics and Conduct	I have been provided electronic access to or received, read, and fully understand G4S Secure Solutions (USA) Inc.'s policy relating to Business Ethics and Conduct. I agree to fully comply with it.	All employees
FM-080 G4S Ethics Code	I have been provided electronic access to or received, read, and fully understand the G4S Ethics Code. I agree to fully comply with it.	All employees
POL-0746 Electronic Communications	I have been provided electronic access to or received, read, and fully understand G4S Secure Solutions (USA) Inc.'s policy on Electronic Communications. I understand that the Company's electronic communications systems are to be used for company business and that excessive use of electronic communications systems for the conduct of personal business is strictly prohibited. I understand that G4S Secure Solutions (USA) Inc. has the right to access, review, and disclose information obtained through its electronic communications systems at any time, with or without advance notice. Further, G4S Secure Solutions (USA) Inc. employees have no reasonable expectation of privacy in electronic communications. I agree to fully comply with this policy.	All employees
POL-0750 Social Networking Policy	I have been provided electronic access to or received, read, and fully understand G4S Secure Solutions (USA) Inc.'s policy relating to Social Networking. I agree to fully comply with it.	All employees
POL-0710 Alcohol- and Drug-Free Workplace Program	I have been provided electronic access to or received, read, and fully understand G4S Secure Solutions (USA) Inc.'s policy relating to the Alcohol- and Drug-Free Workplace Program. I agree not to violate any of the provisions therein.	All employees
FM-200 Employee Concerns Hotline Poster	I have been provided electronic access to or viewed, read, and fully understand G4S Secure Solutions (USA) Inc.'s Employee Concerns Hotline program. I understand that G4S Secure Solutions (USA) Inc. is committed to the highest standards of business ethics and conduct and that employees are encouraged to report concerns about dishonest, unethical or improper conduct - such as violations of company policy or the law - without fear of retaliation.	All employees
POL-0520 / FM-211 Sexual / Workplace Harassment	I have been provided electronic access to or received, read, and fully understand G4S Secure Solutions (USA) Inc.'s policy on Sexual and Workplace Harassment. I understand that it is my responsibility to adhere to this policy, and that failure to do so will be cause for disciplinary action up to and including termination.	POL-0520: Supervisors FM-211: All
POL-0240 Exempt Employee Pay and Salary Deduction	I have been provided electronic access to or received, read, and fully understand G4S Secure Solutions (USA) Inc.'s policy on Exempt Employee Pay and Salary Deductions. I also understand that it is my responsibility to adhere to this policy by immediately informing my supervisor, local area office or the Director, Employee Relations, Corporate Human Resources in writing if I feel that my salary has been subject to an improper deduction.	All exempt employees
POL-0515 EEO and Diversity	I have been provided electronic access to or received, read, and fully understand G4S Secure Solutions (USA) Inc.'s policy on Equal Employment Opportunity (EEO) and Diversity. I also understand that it is my responsibility to adhere to this policy, and that failure to do so will be cause for disciplinary action up to and including termination.	All employees
Horizon Health/Emax Employee Assistance Program Flyer	I have been provided electronic access to or received and read a copy of the Employee Assistance Program (EAP) flyer. I fully understand that the EAP is provided, at no cost to me, twenty-four hours per day, seven days per week. I understand that EAP services are fully confidential and that consultants are available to provide personal counseling and support services and assist in identifying resources to help employees live and work well.	All employees

Employee's Signature

GMA M. Wier

Employee's Printed Name

Ghawn A Wier

Employee's Title

Site Supervisor

HQR Dept. or Field Office

COL 01

Date

12-01-2014



PRODUCTIVITY IMPROVEMENT PROGRAM

Many customers select G4S Secure Solutions (USA) Inc. as their security provider because of our ability to improve their security program and partner with them to reduce costs. In order to accomplish this, G4S Secure Solutions (USA) Inc. looks to employees like you because nobody will know more about your job site and how things can be improved than you.

Productivity improvements may take any one of three forms:

1. The first is a decrease in the cost of contract security services. An example of this would be the installation of technological improvements such as CCTV and/or electronic access control devices.
2. Security personnel assuming additional duties that result in a cost savings to a customer is the second type of improvement. Examples of such duties include receptionist/switchboard operator and interoffice mail delivery.
3. The third type of improvement consists of recommendations that result in a productivity increase for a customer, yet has no direct impact on security. Recommendations on recycling materials or how to streamline the shipping and receiving process are both examples of this type of enhancement.

Make no mistake about it, your suggestions are important to "THINK PRODUCTIVITY." Feel free to contact your local Area Supervisor or call the G4S Productivity Center toll free at 1-888-972-9111 anytime you have a positive suggestion to make.

Signature:

Date:

12-01-2014

Witness:

Date:

12/1/14



**Acknowledgement and Certification
Commitment to Integrity**

I, Shawn A. Wier, on 12-01-2014
(Print Name) (Date)

acknowledge and certify that:

1. I have received a copy of the Commitment to Integrity.
2. I understand the Commitment to Integrity and agree to honor this Commitment as an employee of G4S.
3. I understand that if I have any concerns about this Commitment to Integrity, I may contact my supervisor or manager, or the Employee Concerns Hotline.

Employee Signature



Last 4 digits of Employee's Social Security Number

Instructions to local office: Employee should keep page 1. File page 2 (acknowledgment) in the employee's personnel file.



Protect, Respect, Involve, Develop and Engage

The PRIDE Model is our engagement model used across our global business.

We believe that employee engagement is a critical driver of business success, helping us improve employee stability and increase our employees' motivation to deliver excellent service to our customers, leading in turn to sustainable business performance. Having engaged employees helps us improve service delivery for our customers and in turn increases opportunities for business growth.

To increase levels of employee engagement we continue to align our efforts to the PRIDE model.

P - Protect their basic needs

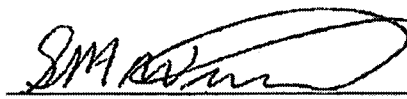
R - Respect them as individuals

I - Involve them in the business

D - Develop their skills and potential

E - Engage them fully

Policies and procedures linked to this model are intended to set clear parameters for action, ensure that the tools and training required to deliver these actions are available and provide for regular feedback on performance and development opportunities in the role.


Signature of Acknowledgement

12-01-2014
Date



Acknowledgement and Certification Your PID and Integrity

I, Shawn A. Wter, on 12-01-2014
(Print Name) (Date)

acknowledge and certify that:

1. I have received a copy of the document titled "Your PID and Integrity: New Employee" that was delivered to me in a sealed envelope.
2. I understand and agree to abide by the terms of this document.
3. I understand that if I have any concerns about the contents of the document titled "Your PID & Integrity," I may contact my supervisor or manager or the Employee Concerns Hotline at (800) 307-9005.

[Signature]
Employee Signature

[Signature]
Supervisor - Witnessing Signature

Instructions to local office: Insert employee's PID number where indicated and provide to employee in a sealed envelope. Once received by the employee, the employee should keep page 1 and sign page 2. The supervisor should witness the employee's signature and file page 2 (Acknowledgment) in the employee's personnel file.



NON-SOLICITATION AGREEMENT

This agreement is made and entered into this 1st day of December, 2014 in Colombia, State of South Carolina, between G4S Secure Solutions (USA) Inc., a Florida corporation, and any of its affiliates, subsidiaries, successors or assigns ("Employer") and Shawn R. Wier ("Employee").

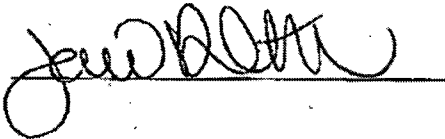
For valuable consideration, including, but not limited to, the employee's employment by the Employer, the parties agree as follows:

1. The Employee acknowledges that during the course of employment he/she will become privy to and obtain knowledge and information, and that the protection of this knowledge and information constitutes a legitimate business interest of the Employer justifying the restrictive covenants herein. The Employee agrees that the Employer's legitimate business interests include, but are not limited to, trade secrets, valuable confidential business or professional information, substantial relationships with specific prospective or existing customers or clients, extraordinary or specialized training or customer goodwill associated with the trade name or service mark of the Employer in a specific geographic location or a specific marketing or trade area.
2. The Employee acknowledges and agrees that the restrictive covenants contained herein are reasonably necessary to protect the legitimate business interest or interests of the Employer justifying these restrictive covenants.
3. **RESTRICTIVE COVENANTS:** The Employee acknowledges and agrees that during employment, he/she will have unique and valuable access to the Company's confidential business information. Furthermore, the Employee will be responsible for developing, maintaining and protecting the Employer's relationships and goodwill with its customers, prospective customers, suppliers, vendors, employees and independent contractors. In recognition of this and other provisions of this Agreement, during his/her employment with the Employer and for a period of two (2) years after the employee's last day of employment, the employee will not, directly or indirectly, or on behalf of or in conjunction with any other person, company, partnership, corporation, business, group or other entity (each, a "Person"):
 - i. Solicit or accept business from any company or person who, within two (2) years prior to the Employee's last day of employment, was a customer of the Employer. In addition, this restriction includes prospective customers of the Employer to whom the Employee contacted or offered to sell services or products on behalf of the Employer; or
 - ii. Solicit, recruit or hire any person employed or contracted by Employer or any person with whom the Employee had regular contact in the course of his/her employment with Employer. Employee understands that damages under this paragraph may be difficult or impossible to determine. Therefore, in addition to injunctive relief, Employee agrees to pay all damages incurred by the Employer including, but not limited to, costs to train the person and the amount spent by Employer to locate and hire the replacement for the person whom Employee solicited.

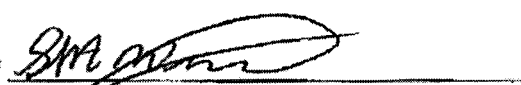
4. The Employee agrees not to divulge, either during or after his/her tenure of employment, any confidential or proprietary information acquired by reason of his/her employment with the Employer to any person. As to any information that constitutes as trade secret, this restriction will extend for a period of ten (10) years. As to any information that is not deemed a trade secret, this restriction will extend for a period of two (2) years.
5. This Agreement may be enforced by an injunction issued by any court to prohibit and restrain any violation or anticipated violation. This may include an injunction restraining the Employee and any other person(s) acting with the Employee from continuance of his/her employment, the rendering of services, the disclosure or use of any information in violation hereof, or any other act in violation of this Agreement. In addition, the Employer may also seek damages for any violation of this Agreement.
6. If any provision of this Agreement is held to be invalid or illegal, all other provisions of this Agreement shall remain in full force and effect.
7. The Employee agrees that if he/she is determined by a court to be in violation of any of the terms of this Agreement, the Employee shall pay all costs of such action, including reasonable attorney's fees.
8. The validity, construction, interpretation or performance of this Agreement shall be governed by the laws of the State of Florida, without regard to the place of execution, performance, construction or interpretation. Florida courts shall have exclusive jurisdiction and venue and any dispute will be litigated only in the State of Florida.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year mentioned above.

Employee
Witness



Employee



Employer
Witness

Employer

CYS Secure Solutions

By, _____

AGY Site Supervisor \$10.50/hr

SHAWN WIER

ADDRESS

7234 Roundstone Drive

Greenville

South Carolina

United States

29629

At this address from Sep 15 2014

CONTACT

Tel: (757) 567-3038

Mobile:

Email: shawnwier@gymnet.com

Website:

Nov 3 2007 - Sep 30 2010

117A
23rd Street
Fort Belvoir
Virginia
22061
United States

Offered: 11/21

CAREER HISTORY

Not Employed

Sep 15 2014 - Nov 2 2014

Relocating to area and searching for job.

Person to contact: Michael Hearn Phone: (254) 310-7535

UNEMPLOYED

Military Service - Branch: Army

Mar 28 2007 - Sep 14 2011

Military Occupation Specialty: 85M

MILITARY

REFERENCES

Reference #1

Available on request

PREVIOUS ADDRESSES

Nov 22 2012 - Sep 14 2014

46672 Thorne Court
Fort Hood
Texas
76544
United States

Oct 1 2010 - Nov 21 2012

5550-2 Empress Ct
Fort Riley
Kansas
66442
United States

ASK-AT

Interview @ 3:30 pm on 11/18

SHAWN WIER

Nov 3 2007 - Sep 30 2016

ADDRESS

7234 Roundstone Drive

Garyville

South Carolina

United States

29359

All in's address from: Sep 19 2014

CONTACT

Tel: (757) 267-3238 (cell)

Work:

Email: shawnwier@gmail.com

Website:

803-663-3616 (hmr)

137 A
23rd Street
Fort Belvoir
Virginia
22064
United States

CAREER HISTORY

Not Employed

Sep 19 2014 - Nov 2 2014

Relocating to area and searching for job.

Person to confirm: Michael E. Pham Phone: (254) 310-7455

UNEMPLOYED

Military Service - Branch: Army

Nov 28 2007 - Sep 14 2014

Military Occupation Specialty: 60A

MILITARY

PREVIOUS ADDRESSES

Nov 22 2012 - Sep 14 2014

45622 Thorne Court
Fort Hood
Texas
76644
United States

Oct 1 2010 - Nov 21 2012

6550-2 Kingsview Dr
Fort Riley
Kansas
66643
United States

REFERENCES

Reference #1

Available on request.

Just out of Military
Gonna send me DD214

- Ticket for abandoned vehicles
- speeding ticket



Disclosure And Authorization To Obtain Consumer Report and/or
Investigative Consumer Report And Release

In connection with my application for employment (including contract for services) with G4S Secure Solutions (USA) Inc., and at any time during any subsequent employment, I understand that consumer reports which may contain public record information may be requested from G4S Compliance & Investigations, 3950 RCA Blvd., Suite 5003, Palm Beach Gardens, Florida 33410, and 800.275.8318. These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, drugs/alcohol use. I further understand that such reports may contain public record information concerning my driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records, in addition to employment, educational verification and personal references.

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED BY G4S SECURE SOLUTIONS (USA) INC. TO FURNISH THE ABOVE-MENTIONED INFORMATION. (A facsimile of this authorization will be construed valid.)

I have the right to make a request to G4S Secure Solutions (USA) Inc., upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including the sources of information; and the recipients of any reports on me which G4S Secure Solutions (USA) Inc. has previously furnished within the two-year period preceding my request. I hereby consent to your obtaining the above information from G4S Secure Solutions (USA) Inc., and I agree that such information that G4S Secure Solutions (USA) Inc. has or obtains, and my employment history with you if I am hired, will be supplied by G4S Secure Solutions (USA) Inc. to other companies which subscribe to G4S Secure Solutions (USA) Inc. I hereby authorize procurement of consumer report(s). If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for you to procure consumer reports at any time during my employment (or contract) period.

Shawn Allen Wier

Print Applicant's Name

[Signature]

Applicant's Signature

[Redacted]

Social Security Number

11-21-2014

Today's Date

[Redacted]

Month and Day of Birth
(DO NOT PUT YEAR OF BIRTH)

Notice to California Applicants: Under California law, the consumer reports we order on you are defined as investigative consumer reports. These reports may contain information on your character, general reputation, personal characteristics and mode of living.

☐ YES, I am a California Applicant and I request to receive a free copy of any investigative consumer report ordered on me by checking this box.

Under section 1788.22 of the California Civil Code, you may view the file maintained on you by G4S Secure Solutions (USA) Inc. during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at G4S Secure Solutions (USA) Inc. in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

MN & OK Residents please note: In connection with your application for employment, your consumer credit report will be obtained and reviewed. Under MN law, if a credit report is requested, you have a right to receive a free copy of your credit report by checking the appropriate box below. Under OK law, you have the right to receive a free copy of your consumer report directly from G4S Secure Solutions (USA) Inc.

☐ YES, I am a Minnesota resident and would like a free copy of my credit report.

☐ YES, I am an Oklahoma resident and would like a free copy of my consumer report.

Author: wier shawn
 Candidate: shawn wier (306129)
 Requisition Title: Upscale Security Officer / Security Guard (Aiken, SC) (SS19304)
 Score: 0
 Document updated on: 11/02/2014
 Questionnaire: Drug and Alcohol Statement Acknowledgement - SS (Version 4)
 Language: English (US)



Agreement Regarding Alcohol- and Drug-Free Workplace Policy and Program and Related Drug and Alcohol Screening

G4S Secure Solutions (USA) Inc. (hereinafter referred to as "G4S USA") is committed to providing a safe work environment and to fostering the well-being and health of its employees. That commitment is jeopardized when any employee illegally uses drugs on the job or in the workplace, or abuses alcohol or prescription medication. In support of G4S USA's commitment to an Alcohol- and Drug-Free Workplace, and as a condition of employment with G4S USA, or any of its subsidiaries,

I, * Shawn A Wier accept the following conditions:

1. I understand that, upon an initial offer of employment, I will be subject to pre-employment drug screening. I also understand that I will not be permitted to commence work with G4S USA until it receives confirmed drug screen results that indicate no illegal drugs or other unauthorized controlled substances were found in my system.
2. I understand that it is a violation of policy for any employee to use, possess, sell, buy, transport, trade, offer for sale, or offer to buy illegal drugs or other non-prescribed intoxicants and controlled substances (or paraphernalia associated with such prohibited substances), or to otherwise engage in the use of such substances on G4S USA or client property, during working hours, while traveling in company or client vehicles, or while on the job in any capacity.
3. I understand it is a violation of G4S USA policy for any employee to report to work or to work under the influence of illegal drugs or other non-prescribed intoxicants and controlled substances, or to report to work or work while possessing in my body, blood or urine, any detectable amount of such substances.
4. I understand it is a violation of G4S USA policy for any employee to report to work or to work under the influence of alcohol or to possess or consume alcohol on G4S USA or client property (except during company-sponsored activities which may include the serving of alcoholic beverages), during working hours or while traveling in company or client vehicles.
5. It is a violation of G4S USA policy for any employee to use prescription drugs illegally or in a manner inconsistent with the physician's prescribed dosage. It is also a violation of G4S USA policy for an employee to report to work while taking prescription drugs that have the effect of impairing the employee's ability to perform his or her job duties in a safe and acceptable manner.

(Nothing in this policy precludes the appropriate use of legally prescribed medications that do not cause unsafe or unacceptable job performance.)

6. If, during my employment, I come forward with the admittance of a substance abuse problem, I understand that G4S USA will permit me to participate in a rehabilitation program if I so choose. I understand that if I need to take a leave of absence for drug or alcohol addiction treatment, this leave may be covered under the Family and Medical Leave Act of 1993 (FMLA).

I understand that to be covered by the FMLA, treatment must satisfy the FMLA's definition of "treatment." Once I return from leave, I understand that I will be subject to another pre-employment drug screening, as well as additional periodic and unannounced follow-up drug and alcohol screening for the 12-month period following my reinstatement.

The number and times of said follow-up screening will be determined by G4S USA management, based upon legitimate business reasons, as well as the requirements and limitations of local, state and federal laws and regulations. If any of these follow-up screening tests indicate I have violated any of G4S USA's policies regarding drug and alcohol abuse, I understand that I will be terminated immediately.

I also agree that regardless of the fact that I have voluntarily disclosed a substance abuse problem to G4S USA, I am obligated to comply with all G4S USA policies, including the policy concerning drug and alcohol abuse and that any violation of said policies will subject me to appropriate disciplinary action, up to and including termination of employment.

7. If I am permitted to remain working for G4S USA while participating in a rehabilitation program, I agree to undergo periodic, unannounced follow-up drug and alcohol screening. The number and times of said screening will be determined by G4S USA management, based upon legitimate business reasons, as well as the requirements and limitations of local, state and federal laws.

I understand that if any of these follow-up screening tests indicate I have violated any of G4S USA's policies regarding drug and alcohol abuse, I will be terminated immediately.

I also understand and agree that regardless of the fact that I have voluntarily disclosed a substance abuse problem to G4S USA, I am obligated to comply with all G4S USA policies, including the policy concerning drug and alcohol abuse and that any violation of said policies will subject me to appropriate disciplinary action, up to and including termination of employment.

8. I understand that if a supervisor suspects that I am under the influence of alcohol or drugs, I will be subject to Reasonable Suspicion testing.

9. I understand that if I drive a patrol vehicle or my personal vehicle while conducting company business, I may be subject to Post-Accident Testing if I am involved in any of the following: accident involving a fatality; accident in which the driver is cited and there is disabling damage to the vehicle(s) requiring tow-away; or an accident in which the driver is cited and off-site medical treatment is required.

10. I understand that, under this policy, all offices, desks, files, computer files, telephones, and lockers are company or client property and that these items can be searched at any time.

11. I understand that if I refuse to cooperate with testing prescribed by G4S USA management, my employment may be terminated.

I understand that none of the provisions herein are intended to alter the fact that I am at all times an employee at will, meaning that I or G4S USA may terminate my employment at any time, for any or no reason not prescribed by law, with or without cause. By my signature below, given freely and without duress, I agree not to violate any of the provisions herein, which identify violations of the G4S USA Alcohol and Drug-Free Workplace Policy and Program.

Signature *

Shawn A Wier

Date *

11/2/2014

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☒ New Hire ☐ Rehire ☐ Promotion ☐ Transfer (Branch to Branch) ☐ Transfer (Site to Site)*

*Employee requested transfers must be accompanied by a written request

Assignment Details

Employee Name: Shawn Wier Branch: COL

Position Title (e.g., TSO, USO, CPO, etc.): Site Supervisor

Effective Date of Assignment: 12/2/2014 Hourly Pay Rate: 10.5

Customer Name and Job Number: AGY

Site Address: 2556 Wagener Rd. Aiken SC 29801
Street Address City State Zip Code

Benefit Program Details: ☒ Medical ☒ Dental ☒ Life ☒ Vision ☒ STD ☐ LTD
☐ Other: None

Vacation Benefit: ☒ Yes ☐ No Describe: 40 hours after 1 year of service

Paid Sick Leave Benefit: ☐ Yes ☒ No Describe: None

Regular Assignment Schedule

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
TBD	TBD	TBD	TBD	TBD	TBD	TBD
TBD	TBD	TBD	TBD	TBD	TBD	TBD

Offer Accepted or Declined?

This offer is contingent upon the successful completion of the pre-employment/assignment screening process, which includes a background investigation and all related employment forms and processes required by G4S Secure Solutions (USA) Inc. or the customer contract. By accepting this site assignment, you agree to work the schedule shown. However, no employee is guaranteed any specific site assignment, shift, post, or location. You may be removed from this site, transferred to a different site, or required to work a different schedule based on the needs of G4S or its customers. Upon your acceptance of the terms of your employment by G4S, you will be employed as an "at will" employee. This means that you or G4S may terminate your employment at any time for any reason or no reason.

I acknowledge that I am not an employee of the above Customer, but may be on property owned or operated by this Customer. I understand that if I am injured at work, I have rights available to me under state workers' compensation laws and I am NOT waiving these rights by signing this Release. I AGREE TO WAIVE, RELEASE AND HOLD HARMLESS CUSTOMER, ITS EMPLOYEES AND INSURERS FROM ALL CLAIMS AND LIABILITY THAT ARISE IN CONNECTION WITH MY EMPLOYMENT INCLUDING, PERSONAL INJURY, DEATH, OR PROPERTY DAMAGE CAUSED IN WHOLE OR IN PART BY CUSTOMER'S NEGLIGENCE OR STRICT LIABILITY. I UNDERSTAND THE TERMS OF THIS RELEASE AND AGREE NOT TO BRING ANY CLAIMS AGAINST CUSTOMER. This Release survives the termination of my employment or this assignment.

☒ Offer Accepted

☐ Offer Declined

If declined, please provide reason:

By signing below, I certify that I have read, understand, and agree to the above terms as a condition of my employment with G4S Secure Solutions (USA) Inc.

Employee Signature

Supervisor Signature

Date

Date

Author: shawnwier@ymail.com
Candidate: shawn wier (306129)
Requisition Title: Upscale Security Officer / Security Guard (Aiken, SC) (SS19304)
Score: 0
Document updated on: 11/22/2014
Profile: Application for Employment - Phase II - all NON Philadelphia, PA positions (Version 14)
Language: English (US)

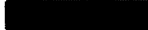


Welcome back! We are excited that you have decided to accept our offer to work for the world's largest provider of security solutions! Because you have accepted a conditional offer of employment, we need to ask you for some important information in order to continue with the recruitment process. Please follow along carefully!

For security purposes, please note that after 30 minutes of inactivity, your session will expire and your submission will be cancelled.

We must require that you provide your date of birth and high school/GED enrollment dates in order to confirm your identity for the purpose of completing an accurate background investigation. It is not provided to the hiring official for any other purpose in connection with consideration of your application for employment.

Date of Birth *



Did you successfully complete a GED? *

- ☒ Yes
☐ No

Test location *

Virginia Beach

Test Date *

03/15/2005

City *

Virginia Beach

State (Please provide 2-digit code.) *

VA

Did you graduate from High School? *

- ☒ Yes
☐ No

I understand that any misrepresentation, falsification or omission of this application shall be sufficient reason for refusal or dismissal of my employment. I hereby authorize investigation of all matters contained in this application and agree that if the results of such investigation are not satisfactory, any offer of employment made by G4S or any subsidiary may be withdrawn, or my employment with G4S may be terminated immediately. I agree to conform and adhere to the rules and regulations of G4S.

Signature *

Shawn A. Wier

Thank you!

Don't forget to regularly visit and login to the G4S Career Center and explore the comprehensive Resource Section, which is full of online video tutorials and advice to support your job application(s). You'll also find a vibrant forum where you can get involved in topical discussions and be a continual part of the G4S community.

If you are a regular Facebook user, please be sure to come and 'Like' and follow our global Facebook page.

12/1/2014

Lumassa TalentLink - Candidate: shawn wler

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GUN CONTROL ACT OF 1968 QUESTIONNAIRE

1. Have you ever been convicted in any court of a misdemeanor crime of domestic violence within the meaning of the Gun Control Act of 1968, as amended? (See definition on following page.)

YES

NO

X

If you answered "YES" to this question, provide the following information with respect to each conviction:

Court / Jurisdiction:

Docket / Case Number:

Statute / Charge:

Date Sentenced:

2. Are you subject to a court order that (A) was issued after a hearing of which you received actual notice, and at which you had an opportunity to participate; and, (B) restrains you from harassing, stalking or threatening an intimate partner or child of such intimate partner, or engaging in other conduct that would place an intimate partner in reasonable fear of bodily injury to the partner or child; and, (C)(i) includes a finding that you represent a credible threat to the physical safety of such intimate partner or child; or, (ii) by its terms explicitly prohibits the use of physical force against such intimate partner or child that would reasonably be expected to cause bodily injury?

If you answered "YES" to this question, provide the following information with respect to each court order:

Court / Jurisdiction:

Docket / Case Number:

Case Name / Parties:

Date of Order:

3. Are you under indictment for, or have you ever been convicted in any court of, a crime punishable by imprisonment for a term exceeding one year, whether or not you were actually imprisoned? If you answered "YES" to this question, provide the following information with respect to each conviction:

Court / Jurisdiction:

Docket / Case Number:

Statute / Charge:

Date Sentenced:

4. Are you a fugitive from justice?

- | | YES | NO |
|---|-----|----------|
| 5. Are you an unlawful user of or addicted to any controlled substance as defined in Section 102 of the Controlled Substances Act? (21 U.S.C. Section 802). | — | <u>X</u> |
| 6. Have you been adjudicated as a mental defective or been committed to a mental institution? | — | <u>X</u> |
| 7. Are you an alien, illegally or unlawfully in the United States, or have you been admitted to the U.S. under a nonimmigrant visa? (see 8 U.S.C. Section 1101 (a)(26)) | — | <u>X</u> |
| 8. Have you been discharged from the Armed Forces under dishonorable conditions? | — | <u>X</u> |
| 9. Have you renounced or given up your United States citizenship? | — | <u>X</u> |

DEFINITION

As defined in the Gun Control Act as amended, a "misdemeanor crime of domestic violence" means an offense that:

1. is a misdemeanor under Federal or State law, and
2. has, as an element, the use or attempted use of physical force, or the threatened use of a deadly weapon, committed by a current or former spouse, parent, or guardian of the victim, by a person with whom the victim shares a child in common, by a person who is cohabiting with or has cohabited with the victim as a spouse, parent or guardian, or by a person similarly situated to a spouse, parent or guardian of the victim. (18 U.S.C. Section 821 (a) (33) (A)).

This definition includes all misdemeanors that involve the use or attempted use of physical force (e.g., simple assault, assault and battery) if the offense is committed by one of the defined parties. This is true whether or not the State statute or local ordinance specifically defines the offense as a domestic violence misdemeanor. For example, a person convicted of misdemeanor assault against his or her spouse would be prohibited from receiving or possessing firearms or ammunition. Moreover, the prohibition applies to persons convicted of such misdemeanors at any time, even if the conviction occurred prior to the new law's effective date, September 30, 1996. As of the effective date of the new law, such a person may no longer possess a firearm or ammunition. However, with respect to all persons, a conviction would not be disabling if it has been expunged, set aside, pardoned, or the person has had his or her civil rights restored (if the law of the applicable jurisdiction provides for the loss of civil rights under such an offense) AND the person is not otherwise prohibited from possessing firearms or ammunition.

I hereby certify that to the best of my knowledge and belief, all of the information provided by me on this Gun Control Act Questionnaire is true, correct, complete and made in good faith. I understand that false or fraudulent information provided herein may be grounds for adverse action, up to and including termination, and is also criminally punishable pursuant to federal law.

I acknowledge my obligation to notify G4S Secure Solutions (USA) Inc. within five (5) working days, as long as I remain in its employ, of any future offenses or circumstances which would require me to answer "YES" to any of the above questions.

EMPLOYEE:

Shawn A. Wier
Print Name

[Signature]
Signature

12-01-2014
Date

WITNESS:

Jamie Prickett
Print Name

[Signature]
Signature

12/1/14
Date



Quest
Diagnostic



Order Expiration Date / Time: 11/25/2014 4:00:00 PM Eastern

Authorization Barcode #: 9819629

Employer Information:

G4S Corporation
7200 US HIGHWAY 441 NORTH
OKEECHOBEE, FL 34972
Phone: (561)691-6484
Fax:

Medical Review Officer:

SETH PORTNOY, DO
5440 NW 33RD AVE STE 106
FORT LAUDERDALE, FL 33309
Phone: (954)677-1200
Fax: (954)677-1201

Location: G4S SS COL

Test Information

Donor Information:
Shawn Wier
[REDACTED]

Test Details:
Reason for test: Pre-Employment
Account [REDACTED]

Service(s) to be Performed

UR Drug Screening

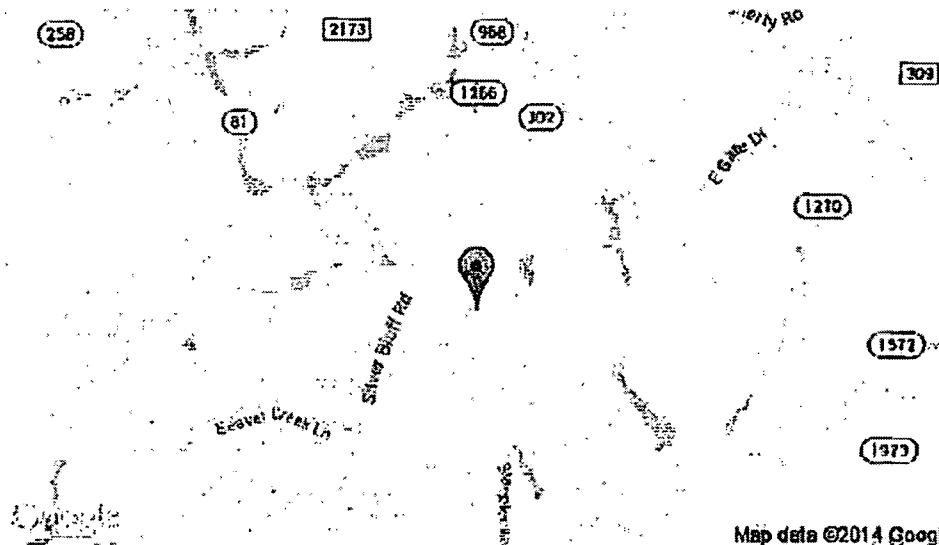
36455N

SAP 950

Collection Site Information

Business and Industry Health
440 Society Hill Dr
Aiken, SC 29803
803-642-2885
M-F 8:00 am-11:00 am & 1:00 pm-4:00
pm

Please bring your driver's license or other government issued photo-ID with you for identification at the collection facility.



You must bring this order confirmation to the collection facility!

National Customer Service (800) 877-7484

Quest
Diagnostics

11/25/2014 7:17:08 AM

Drug Detail Report

PATIENT INFORMATION
SHAWN WIERQuest Diagnostics Employer Solutions
Customer Care: 800-877-7484

Primary ID: [REDACTED]

Collection Site: Business and Industry Health
440 Society Hill Dr
Aiken, SC 29803
803-642-2885

CLIENT INFORMATION

[REDACTED]
G4S SS COL
240 STONERIDGE DR
COLUMBIA, SC 29210

SPECIMEN INFORMATION

REQUISITION: 1148819
LAB REF NO: 344496S
COLLECTED: 11/24/2014 09:31
RECEIVED: 11/25/2014 02:20
REPORTED: 11/25/2014 06:38
DOCUMENT ID: 5004620261

Reason: PRE-EMPLOYMENT

Tests Ordered: 36455N

Substance Abuse Panel

		Initial Test Level	GC/MS Confirm Test Level
AMPHETAMINES	Negative	1000 ng/mL	500 ng/mL
BARBITURATES	Negative	300 ng/mL	200 ng/mL
BENZODIAZEPINES	Negative	300 ng/mL	300 ng/mL
COCAINE METABOLITES	Negative	300 ng/mL	150 ng/mL
MARIJUANA METABOLITES	Negative	50 ng/mL	15 ng/mL
METHADONE	Negative	300 ng/mL	300 ng/mL
OPIATES	Negative	2000 ng/mL	2000 ng/mL
PHENCYCLIDINE	Negative	25 ng/mL	25 ng/mL
PROPOXYPHENE	Negative	300 ng/mL	300 ng/mL

CERTIFYING SCIENTIST: APKR01

SPECIMEN RECEIVED AND PROCESSED IN THE ATLANTA DHHS CERTIFIED LABORATORY

LAB: Quest Diagnostics-Atlanta (NIDA)
1777 Montreal Circle
Tucker GA 30084

SECRET
TYPE 1120: 11/00001

McGraw-Hill's *CPA Exam Study Guide* for chosen state CPA exam. <http://www.mhprofessional.com/cpa>

Over 500 of the Best

SUBJECT: JAVELIN

STANDARD 425/46 (1993) AND 425/46

PRICE: \$0.99
ISSN: 1043-9862/01/0100

Page 3 of 4

ॐ नमो भगवते वासुदेवाय
ॐ नमो भगवते वासुदेवाय

A Summary of Your Status Under the Fair Credit Reporting Act

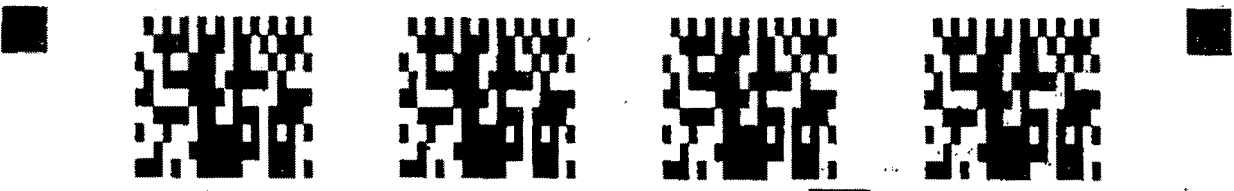
• You attach the table of information to your file but have used a false name. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment -- or to take another adverse action against you -- must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- In addition, all subscribers will be notified 15 days prior to each issue every 12 months upon request from each nation. (The world's largest and most reliable source of information regarding companies. See www.whois.com for more details.)

- 10 We have the right to ask for a credit score. Credit scores are numerical assessments of your credit-worthiness based on information from credit bureaus. We may request a credit score from you after requesting a credit score report. If a credit score is used in a prohibited and proprietary basis, but you still have to pay for it. In some cases, your credit score will receive credit score information that they have the right to use.

6. The user has the right to dispute incomplete or otherwise inaccurate information about the user's background or character, and request that the company or agency agree to the agency must have the user prove the dispute is the right. The user must provide evidence to the company or agency to prove the dispute.

- Companies reporting a previous report, must not or should have been, submitting a 100% reliable letter to the Commission, providing or verifiable information can be received or corrected, usually within 30 days. However, a company reporting agency may survive to report information it has verified as accurate.
- Companies reporting a previous report, a report submitted and accurate information. In case some, a company reporting agency may not require people if it determines if it is more than an year old, or information that are more than 10 years old.
- Agents to give you the feedback. A company reporting agency may provide information in what you only to pay with a valid email - or actually to consider an application with a similar, internet, company, limited, or other business. The FICRA requires those who is a valid need for access.
- The most give you a comment for reports to be provided to employers. A company reporting agency may not give information about you to your employer, or a personal employer, without your written consent given to the employer. Written consent given by the individual in the health industry. For more information, go to



Urgent Fax Request

To: Dondra Bible

Fax: 803-256-0788

From: ncowles

Pgs: 1

RE: Request for Missing Information



Compliance & Investigations

3950 RCA Blvd
Palm Beach Gardens, FL 33410
Telephone: (800) 275-8318
Fax: 800-275-8319

Cg:M1429855:S0:FD:26840

Name of applicant: shawn allen wier

Employee Number: 

DOB: 

Notice: We are unable to process certain elements of this subject's background because required information is not available to us. That missing information is outlined in Section 1 below. Please provide that missing information or your instructions in Section II below and fax this form, with additional documents if necessary, to 866-439-4065. This page must be page one when faxing a response to this request.

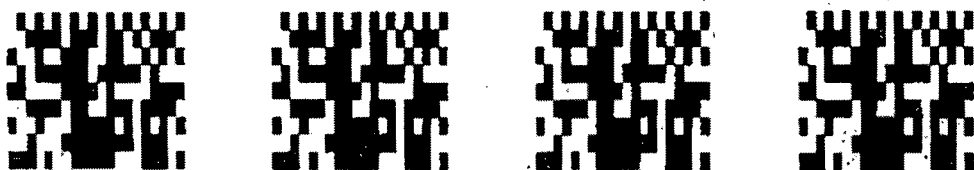
Section 1 (request for missing information or instructions):

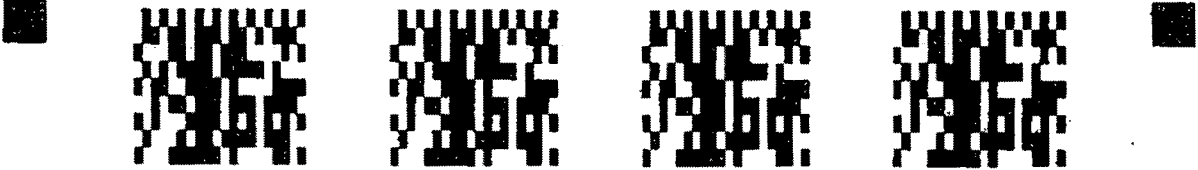
Please have the Subject provide an additional reference. The Subject provided an additional reference, Taylor White; however, there is no voice mail setup and unable to leave him a message. Please provide as soon as possible so that the Subject's file can be completed. Thank you.

Section II (Your response to missing information or instructions):

1) Jen Mahorney (757) 748-6419

FAX COVER





Urgent Fax Request

To: Dondra Bible



Compliance & Investigations

Fax: 803-256-0788

3950 FCA Blvd.
Palm Beach Gardens, FL 33410
Telephone: (800) 275-8318
Fax: 800-275-8319

From: ncowles

Pgs: 1

Cg:M1429855:S0:FD:25245

RE: Request for Missing Information

Name of applicant: shawn allen wler

Employee Number: 

DOB: 

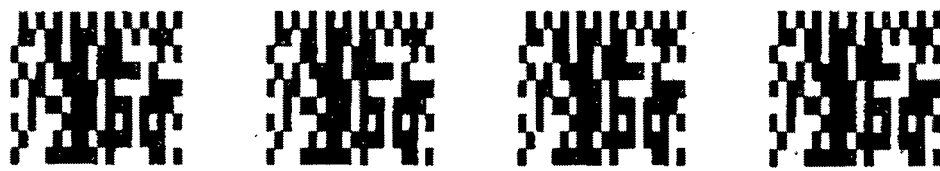
Notice: We are unable to process certain elements of this subject's background because required information is not available to us. That missing information is outlined in Section 1 below. Please provide that missing information or your instructions in Section II below and fax this form, with additional documents if necessary, to 866-439-4065. This page must be page one when faxing a response to this request.

Section 1 (request for missing information or instructions):

Please provide a copy of the Subject's DD214. I spoke with the Subject today and he stated that you have a copy already. Thank you.

Section II (Your response to missing information or instructions):

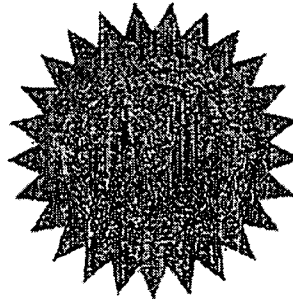
FAX COVER



MEMBER - 4

400247855408

Commonwealth of Virginia



GENERAL EDUCATIONAL DEVELOPMENT

This certificate is awarded to

SHAWN A WIER

in lieu of a high school diploma for having made acceptable scores on a comprehensive approved battery of standardized tests of general educational development in the following high school subject fields: writing skills, social studies, science, literature and the arts, and mathematics

Issued by the Virginia Department of Education on this day

February 26, 2005

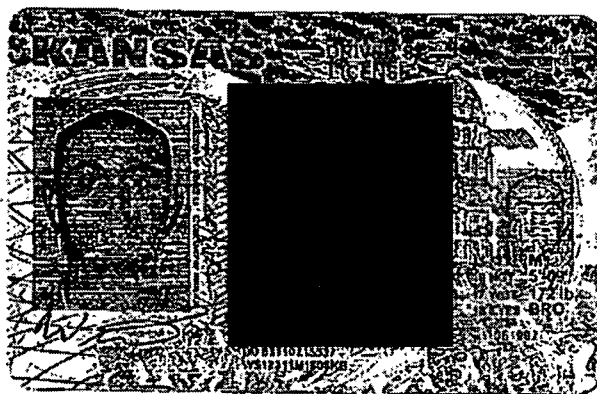
Robert W. MacGillivray

Robert W. MacGillivray
GED State Administrator

14 March 2005

Jo Lynne DeMary

Jo Lynne DeMary
Superintendent of Public Instruction





G4S NORTH AMERICA TRAINING INSTITUTE (NATI) TRAINING CHECKLIST

PERSONAL DATA			
NAME	LAST	FIRST	MIDDLE DATE
	Wier	Shawn	Allen 12-01-2014
LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER		AREA/BRANCH/FACILITY	
[REDACTED]		Col 01	
CITY		STATE	ZIP CODE
Columbia		SC	29210

PRE-ASSIGNMENT TRAINING

TOPIC	DATE	LENGTH	SUCCESSFUL COMPLETION		COMMENTS
			EMP. INITIALS	SUP. INITIALS	
STATE-REQUIRED TRAINING	12/2/14	4hr	SW	DB	Passed
COMPLETED SECURITY OFFICER HANDBOOK EXAM	12/2/14	1.5hr	SW	DB	Passed
COMPLETED SAFETY HANDBOOK EXAM	12/2/14	1hr	SW	DB	Passed
COMPLETED TSO TRAINING					
COMPLETED USO TRAINING	12/4/14	4Dhr	SW	DB	Passed
COMPLETED CPO TRAINING					
COMPLETED PRO TRAINING					
LM-99 (Level II Employees)	12/3/14		SW	DB	Passed
SPX-0104 (Level I Employees)					
UM-09	12/3/14		SW	DB	Passed
CPB/First Aid/AED	12/3/14	1hr	SW	DB	↓
EP-22	12/2/14		SW	DB	↓

ARMS QUALIFICATION (ATTACH RANGE CARD)

COURSE	DATE	QUALIFIED YES / NO	INSTRUCTOR'S SIGNATURE	REQUALIFICATION DATES	INSTRUCTOR'S SIGNATURE

RAINING CHECKLIST (CONTINUED), CONTINUING EDUCATION

[illegible]

* e.g., SP-205, SP-205, LDC-WAS-0010

FM-037 (01/13/14)

Page 2 of 3

TRAINING CHECKLIST (CONTINUED)
SKILLS PERFORMED UNDER OBSERVATION

[illegible]

* e.g., Use of Fire Extinguisher, Use of Magnetometer, Badge Checking Procedure

FM-037 (01/13/14)

Page 3 of 3



G4S NORTH AMERICA
TRAINING INSTITUTE

PRESENTS THIS

Certificate of Completion

TO

Shawn Weir

FOR

Upscale Security Officer Program (40-Hour Course)

ON

12/04/2014

A handwritten signature in black ink, appearing to read "Kerwin D. Brown", written over a horizontal line.

General Manager/Project Manager

A handwritten signature in black ink, appearing to read "Daniel W. Grizzard", written over a horizontal line.

Daniel W. Grizzard
Chief Operating Office
G4S Secure Solutions (US)

-3 97%



100-QUESTION CONSOLIDATED ANSWER SHEET

Name: Shawn A Wier	Date: 4 Dec 2014
Office: COL	USO Final Exam

1.	T	F	A	B	C	D	E	26.	T	F	A	B	C	D	E
2.	T	F	A	B	C	D	E	27.	T	F	A	B	C	D	E
3.	T	F	A	B	C	D	E	28.	T	F	A	B	C	D	E
4.	T	F	A	B	C	D	E	29.	T	F	A	B	C	D	E
5.	T	F	A	B	C	D	E	30.	T	F	A	B	C	D	E
6.	T	F	A	B	C	D	E	31.	T	F	A	B	C	D	E
7.	T	F	A	B	C	D	E	32.	T	F	A	B	C	D	E
8.	T	F	A	B	C	D	E	33.	T	F	A	B	C	D	E
9.	T	F	A	B	C	D	E	34.	T	F	A	B	C	D	E
10.	T	F	A	B	C	D	E	35.	T	F	A	B	C	D	E
11.	T	F	A	B	C	D	E	36.	T	F	A	B	C	D	E
12.	T	F	A	B	C	D	E	37.	T	F	A	B	C	D	E
13.	T	F	A	B	C	D	E	38.	T	F	A	B	C	D	E
14.	T	F	A	B	C	D	E	39.	T	F	A	B	C	D	E
15.	T	F	A	B	C	D	E	40.	T	F	A	B	C	D	E
16.	T	F	A	B	C	D	E	41.	T	F	A	B	C	D	E
17.	T	F	A	B	C	D	E	42.	T	F	A	B	C	D	E
18.	T	F	A	B	C	D	E	43.	T	F	A	B	C	D	E
19.	T	F	A	B	C	D	E	44.	T	F	A	B	C	D	E
20.	T	F	A	B	C	D	E	45.	T	F	A	B	C	D	E
21.	T	F	A	B	C	D	E	46.	T	F	A	B	C	D	E
22.	T	F	A	B	C	D	E	47.	T	F	A	B	C	D	E
23.	T	F	A	B	C	D	E	48.	T	F	A	B	C	D	E
24.	T	F	A	B	C	D	E	49.	T	F	A	B	C	D	E
25.	T	F	A	B	C	D	E	50.	T	F	A	B	C	D	E

100%



25-QUESTION CONSOLIDATED ANSWER SHEET

Name: <i>Shawn A. Wier</i>	Date: <i>12-3-2014</i>
Office: <i>COL</i>	<i>LM-99</i>

1.	T	F	A	☒ B	C	D	E
2.	T	☒ F	A	B	C	D	E
3.	T	F	☒ A	B	C	D	E
4.	☒ T	F	A	B	C	D	E
5.	T	F	A	B	C	☒ D	E
6.	T	F	A	B	C	☒ D	E
7.	T	☒ F	A	B	C	D	E
8.	T	F	A	☒ B	C	D	E
9.	☒ T	F	A	B	C	D	E
10.	T	F	A	B	C	D	☒ E
11.	☒ T	F	A	B	C	D	E
12.	T	F	☒ A	B	C	D	E
13.	T	☒ F	A	B	C	D	E
14.	T	F	A	B	C	☒ D	E
15.	☒ T	F	A	B	C	D	E
16.	T	F	A	B	C	D	E
17.	T	F	A	B	C	D	E
18.	T	F	A	B	C	D	E
19.	T	F	A	B	C	D	E
20.	T	F	A	B	C	D	E
21.	T	F	A	B	C	D	E
22.	T	F	A	B	C	D	E
23.	T	F	A	B	C	D	E
24.	T	F	A	B	C	D	E
25.	T	F	A	B	C	D	E

100%



25-QUESTION CONSOLIDATED ANSWER SHEET

Name: <u>Shawn A. Wier</u>	Date: <u>3 Dec 2014</u>
Office: <u>COL</u>	<u>LM-09</u>

1.	T	F	A	B	C	D	E
2.	T	F	A	B	C	D	E
3.	T	F	A	B	C	D	E
4.	T	F	A	B	C	D	E
5.	T	F	A	B	C	D	E
6.	T	F	A	B	C	D	E
7.	T	F	A	B	C	D	E
8.	T	F	A	B	C	D	E
9.	T	F	A	B	C	D	E
10.	T	F	A	B	C	D	E
11.	T	F	A	B	C	D	E
12.	T	F	A	B	C	D	E
13.	T	F	A	B	C	D	E
14.	T	F	A	B	C	D	E
15.	T	F	A	B	C	D	E
16.	T	F	A	B	C	D	E
17.	T	F	A	B	C	D	E
18.	T	F	A	B	C	D	E
19.	T	F	A	B	C	D	E
20.	T	F	A	B	C	D	E
21.	T	F	A	B	C	D	E
22.	T	F	A	B	C	D	E
23.	T	F	A	B	C	D	E
24.	T	F	A	B	C	D	E
25.	T	F	A	B	C	D	E

100



25-QUESTION CONSOLIDATED ANSWER SHEET

Name: <i>Shawn A Wier</i>	Date: <i>12-2-14</i>
Office: <i>COL</i>	<i>SO Handbook</i>

1.	☒	F	A	B	C	D	E
2.	☐	F	A	B	C	D	E
3.	☐	F	A	B	C	D	E
4.	☐	F	A	B	C	D	E
5.	☐	F	A	B	C	D	E
6.	☐	F	A	B	C	D	E
7.	☐	F	A	B	C	D	E
8.	☐	F	A	B	C	D	E
9.	☐	F	A	B	C	D	E
10.	☐	F	A	B	C	D	E
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15.	☐	F	A	B	C	D	E
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18.	☐	F	A	B	C	D	E
19.	☐	F	A	B	C	D	E
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22.	☐	F	A	B	C	D	E
23.	☐	F	A	B	C	D	E
24.	☐	F	A	B	C	D	E
25.	☐	F	A	B	C	D	E



G4S Secure Solutions USA

Safety Handbook Acknowledgement and Consent Agreement

I, Shawn A. Wier have received a copy and read the G4S Safety Handbook and understand the content. I have had the opportunity to ask questions and fully understand the meaning and intent of this safety program and policies. Additionally, I understand I should contact my supervisor with any further or future questions regarding the G4S Safety Handbook or program.

By signing below, I acknowledge having received a copy of the G4S Safety Handbook and consent to abide by the contents.

Shawn A. Wier

Signature

12-01-2014

Date

Jan Dett

Witness Signature

12/1/14

Date

Completion of this test is required and must be noted in the individual's training record. This test is duplicated as an appendix to the Safety Handbook. Either this version or the appended version may be used.

100



25-QUESTION CONSOLIDATED ANSWER SHEET

Name: <i>Shawn A Wier</i>	Date: <i>12-2-14</i>
Office: <i>CDI</i>	Safety Handbook

1.	☒	F	A	B	C	D	E
2.	T	F	A	B	☒	D	E
3.	T	F	☒	B	C	D	E
4.	T	F	A	☒	C	D	E
5.	☒	F	A	B	C	D	E
6.	T	F	A	B	C	☒	E
7.	T	F	A	B	C	☒	E
8.	T	F	A	B	C	☒	E
9.	T	F	A	☒	C	D	E
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18.	T	F	A	☒	C	D	E
19.	T	F	A	☒	C	D	E
20.	T	F	A	B	☒	D	E
21.	T	F	A	B	C	☒	E
22.	☒	F	A	B	C	D	E
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24.	T	F	A	B	☒	D	E
25.	T	F	A	☒	C	D	E

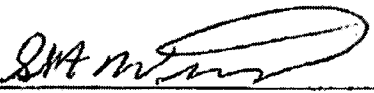


G4S Secure Solutions USA

**Putting Safety First Motor Vehicle, Golf Cart and Bicycle Safety
Acknowledgement and Consent Agreement**

I Shawn A Wier viewed the G4S Putting Safety First Motor Vehicle, Golf Cart and Bicycle Safety Video and understand the content. I have had the opportunity to ask questions and fully understand the meaning and intent of this safety program and policies. Additionally, I understand I should contact my supervisor with any further or future questions regarding the G4S Driving Safety policy.

By signing below, I acknowledge having receipt of this program and consent to abide by the contents.


Signature

12-01-2014
Date


Witness Signature

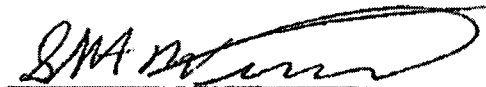
12/1/14
Date



YOUTH HANDGUN SAFETY ACT NOTICE RECEIPT

I, Shawn A. Wier, have received, read and understand the

contents of the Youth Handgun Safety Act Notice (ATF Information 5300.2). I also understand that it is my responsibility to adhere to all contents therein.


Signature

12-01-2014
Date

Shawn A. Wier
Print Name

COL 01
Department and/or Location

100



25-QUESTION CONSOLIDATED ANSWER SHEET

Name: Shawn Wier	Date: 12-2-14
Office: 201	Sted I Exam

1.	T	F	A	B	C	D	E
2.	T	F	A	B	C	D	E
3.	T	F	A	B	C	D	E
4.	T	F	A	B	C	D	E
5.	T	F	A	B	C	D	E
6.	T	F	A	B	C	D	E
7.	T	F	A	B	C	D	E
8.	T	F	A	B	C	D	E
9.	T	F	A	B	C	D	E
10.	T	F	A	B	C	D	E
11.	T	F	A	B	C	D	E
12.	T	F	A	B	C	D	E
13.	T	F	A	B	C	D	E
14.	T	F	A	B	C	D	E
15.	T	F	A	B	C	D	E
16.	T	F	A	B	C	D	E
17.	T	F	A	B	C	D	E
18.	T	F	A	B	C	D	E
19.	T	F	A	B	C	D	E
20.	T	F	A	B	C	D	E
21.	T	F	A	B	C	D	E
22.	T	F	A	B	C	D	E
23.	T	F	A	B	C	D	E
24.	T	F	A	B	C	D	E
25.	T	F	A	B	C	D	E

SOUTH CAROLINA LAW ENFORCEMENT DIVISION



State of South Carolina)

County of Richland)

PROOF OF TRAINING AND VERIFICATION OF INSTRUCTION IN LAW AND ARREST PROCEDURES:

NAME OF SECURITY OFFICER: Shawn A. Wier
(PLEASE PRINT)

NAME OF SECURITY COMPANY: G4S SECURITY SOLUTIONS
(PLEASE PRINT)

NAME OF TRAINING OFFICER: DUSTIN BOWAL
(PLEASE PRINT)

On December 2nd, 2014, the above named officer successfully completed instruction in selected security principles topics. A minimum of four (4) hours instruction was furnished to the officer, and the following tasks were completed:

- (A) Officer was instructed in legal issues, including search and seizure, and laws of arrest.
- (B) Officer was instructed in arrest procedures and techniques.

I certify the above to be accurate, and I have successfully completed the training required by SLED to instruct security officers in these subjects, and I AM CURRENTLY REGISTERED AS A SECURITY OFFICER.

I certify that I have received the training described above.

[Signature]
Signature of Security Officer

[Redacted]
Social Security Number

Date of birth: [Redacted]

[Signature]
Training Officer (Signature)

10/15/2015
Expiration date of Registration Card

[Redacted]
Certificate Number

Date: 12/02/2014

PD/PS-2/07:6/07



An Accredited Law Enforcement Agency

P.O. Box 21398 / Columbia, South Carolina 29221-1398 / (803) 737-9000 / Fax (803) 896-7041



APPLICATION FOR SECURITY/PRIVATE INVESTIGATIVE REGISTRATION

SOUTH CAROLINA LAW ENFORCEMENT DIVISION

Post Office Box 21398
Columbia, SC 29221-1398

ATTN: PUBLIC DISSEMINATION

FILE # R

NOTICE: Application must be typed or clearly printed in ink. All questions must be answered, if applicable. If not, indicate N/A (not applicable). Applications which are not complete and legible will be returned. If space provided is not sufficient for complete answers or you wish to furnish additional information, attach sheets of the same size as the application, and number answers to correspond with the questions.

THIS APPLICATION IS FOR EMPLOYEE REGISTRATION AS:

SECURITY/PRIVATE INV.

SECURITY ONLY

☒ NEW☐ ARMED☐ RE-REGISTERING☒ UNARMED

AGENCY NAME:

CO. LICENSE #:

MAILING ADDRESS:

CITY/STATE:

ZIP CODE:

G4S Secure Solutions (USA) Inc.

1370 Browning Rd Ste. 110

Center Point 5

Columbia, SC 29210

803-256-7090

PHONE #:

1. PERSONAL HISTORY

Full Name (Last, First, Middle)

Driver's License #

Wier, Shawn A

Date of Birth

Place of Birth (City & State)

Social Security #

Race

Sex

Height

Weight

Eyes

Hair

[REDACTED]

[REDACTED] FL

[REDACTED]

C

M

5'9"

224

Brown

Brown

PLEASE NOTE: SOCIAL SECURITY NUMBER IS NECESSARY IN ORDER TO OBTAIN AN ACCURATE CRIMINAL HISTORY CHECK.

Are you a U.S. citizen? ☒ Yes ☐ No

NATURALIZATION NO:

PLACE:

COURT:

2. RESIDENCES

Present Residence Address (Street, City, State, Zip Code)

7234 Roundstone Drive Graniteville SC, 29829

Home Phone #

Cell Phone #

[REDACTED] (757) 867-3938

PRIOR Resident Address(s) - include the past 10 years (Street, City, State, Zip Code) - Use additional space on back, if required.

How Long?

1. 48622 Thorne Court Fort Hood TX 76544

2 yrs

2. Fort Riley KS,

2 yrs

3. Fort Eustis Va

3 yrs

4. Va Beach Va

3 yrs

Have you previously applied for a Security License with the S. C. Law Enforcement Division?

Do you currently hold a State Constable's Commission?

☒ No ☐ Yes Date: _____ Place: _____☒ No ☐ Yes Date: _____

3. EMPLOYMENT

List chronologically all employments for the past 10 years, including summer and part-time employments while attending school. All time must be accounted for. If unemployed for a period indicate, setting forth dates of unemployment (If space provided is insufficient, continue on a separate page.)

Name, Address and Phone # of Employer	Date From To	Position and type of work	Name of Supervisor	Reason for Leaving
a. US Army	2007/05/01 2014/14/09	Heavy vehicle operator	SSG Collins	Medical Retirement
b. Merchants Va beach Va	2006/04 2006/12/12	Mechanic	Unknown	Joined U.S. Army
c. Jiffy lube Va beach Va	2006/01 2006/06/25	Assistant Manager	Unknown	Transferred to Merchants
d.				

Do you currently hold any other position where you have direct or indirect access to criminal history information? ☒ No ☐ Yes

4. MILITARY RECORDS

Have you ever served on active duty in the Armed Forces of the United States?

Branch of Military Service

Type of Discharge

☐ No ☒ Yes Highest Rank Obtained? E-5

US Army

Honorable

86.5



25-QUESTION CONSOLIDATED ANSWER SHEET

Name: Shawn A. Wier	Date: 3 Dec 14
Office: GDL	LP-30

1.	T	F	A	B	C	☒	E
2.	T	☒	A	B	C	D	E
3.	T	F	A	B	☒	D	E
4.	T	F	A	B	C	D	☒
5.	T	F	A	B	C	D	☒
6.	T	☒	A	B	C	D	E
7.	T	F	A	B	C	☒	E
8.	T	F	A	☒	C	D	E
9.	T	F	A	B	C	D	☒
10.	T	F	A	B	C	☒	E
11.	T	F	A	B	C	D	☒
12.	T	F	A	B	☒	D	E
13.	T	F	A	B	C	☒	E
14.	T	F	☒	B	C	D	E
15.	T	☒	A	B	C	D	E
16.	T	F	A	B	C	D	E
17.	T	F	A	B	C	D	E
18.	T	F	A	B	C	D	E
19.	T	F	A	B	C	D	E
20.	T	F	A	B	C	D	E
21.	T	F	A	B	C	D	E
22.	T	F	A	B	C	D	E
23.	T	F	A	B	C	D	E
24.	T	F	A	B	C	D	E
25.	T	F	A	B	C	D	E

100 %



25-QUESTION CONSOLIDATED ANSWER SHEET

Name: <i>Shawn A. Wier</i>	Date: <i>3 Dec 2014</i>
Office: <i>COL</i>	EP-27

1.	T	F	A	☒ B	C	D	E
2.	T	F	☒ A	B	C	D	E
3.	T	F	☒ A	B	C	D	E
4.	T	F	A	B	☒ C	D	E
5.	T	F	A	B	C	☒ D	E
6.	T	F	A	B	☒ C	D	E
7.	T	F	A	☒ B	C	D	E
8.	T	F	☒ A	B	C	D	E
9.	T	F	A	☒ B	C	D	E
10.	T	F	A	B	☒ C	D	E
11.	T	F	A	B	C	D	E
12.	T	F	A	B	C	D	E
13.	T	F	A	B	C	D	E
14.	T	F	A	B	C	D	E
15.	T	F	A	B	C	D	E
16.	T	F	A	B	C	D	E
17.	T	F	A	B	C	D	E
18.	T	F	A	B	C	D	E
19.	T	F	A	B	C	D	E
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21.	T	F	A	B	C	D	E
22.	T	F	A	B	C	D	E
23.	T	F	A	B	C	D	E
24.	T	F	A	B	C	D	E
25.	T	F	A	B	C	D	E



Employee Driver's Acknowledgement Form

I, Shawn A. Wier, hereby acknowledge that in the course of my duties I will be driving a Vehicle owned or leased by G4S or G4S Customer (hereinafter "Vehicle").

Driver's License:

- I understand that I must maintain a current valid driver's license. I understand that I am required to inform my supervisor of any driving stops or citations, as well as any changes in my driving status, specifically a suspension, cancellation or revocation of a license within 24 hours or the next business day from the date of the action.

Safety:

- I agree to wear a seat belt at all times during Vehicle operation and will require passengers to wear seat belts.
- I agree to use a cell phone only in hands-free mode and will not text while driving. In the event use of a cell phone while driving is prohibited by law, Customer policy, site policy or G4S policy, I agree not to use a cell phone while driving.
- I agree the use of radar detectors, laser detectors or similar devices is strictly prohibited in the Vehicle at all times.
- I will not operate vehicle at any time when my ability to do so is impaired, affected, influenced by alcohol, illegal drugs, prescribed or over-the-counter medication, illness, fatigue or injury.
- I agree to abide by all applicable rules, regulations and laws pertaining to the operation of a Vehicle.

Accidents:

- I understand that if I am involved in a vehicle accident while on work related business, or otherwise, that I must report it to my immediate (or available) supervisor immediately, or if hospitalized or in a remote location, as soon as possible, and that I may be required to submit to an alcohol and drug test. I also agree to cooperate with any police, law enforcement, G4S, G4S Customer or insurance investigations or inquiries related to the accident.

General:

- I agree not to smoke or use tobacco products of any kind in the Vehicle or to allow passengers to do so.
- I agree not to eat or allow passengers to eat in the Vehicle.
- I understand that I am not authorized to utilize the Vehicle for personal use.
- I understand that passengers not related to formal G4S business activities are not allowed the Vehicle.

I am responsible for maintaining the Vehicle in a clean and professional fashion at all times.

Citation, Damage, Theft, Loss:

I understand that I will be responsible to pay for any driving or parking/toll citation, regardless if it is received while driving Vehicle, incurred by me or as a result of my actions or inactions. I understand and agree to use due care to prevent theft, loss, or damage to the Vehicle. I understand and agree that I will be personally responsible for the replacement or repair costs if the Vehicle is damaged, lost or stolen as a result of my negligence. I understand and agree that I may be subject to disciplinary action up to and including termination for the misuse of or damage to company or customer property. I agree to complete FM-125 Payroll Deduction Form and allow any such costs to be deducted from my paycheck to the extent permitted by law.

<u>Wier</u> Last Name	<u>Shawn</u> First Name	<u>A</u> Middle Initial
<u>[REDACTED]</u> Driver's License Number	<u>KS</u> State	<u>11-06-2018</u> Expiration Date

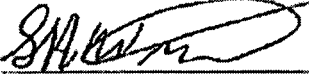
Employee Signature: [Signature] Date: 12-01-2014

Supervisor Signature: [Signature] Date: 12/1/14



**MOTOR VEHICLE REPORT (MVR)
AND DRUG AND ALCOHOL TESTING CONSENT FORM**

I [print name] Shawn A. Wier ☒ [do] [do not] [circle one]
give my consent for G4S Secure Solutions (USA) Inc. to complete a background check
on my previous driving record. As part of this procedure, the company has my
permission to order Motor Vehicle Records (MVRs) from any and all states that I have
currently and previously held a driver's license. I understand that G4S Secure Solutions
(USA) Inc. has an established MVR review program that my driving history will be
compared against to determine my driving eligibility. I further consent to controlled
substance drug and alcohol testing following any vehicle accident, regardless of whether
any passengers or I are injured as a result. I further understand that failure to release
consent for G4S Secure Solutions (USA) Inc. to conduct a background check on my
previous driving record means that I forfeit my driving privileges and/or employment with
the company.


Signature

12-01-2014
date



DRIVER TRAINING ARTICLES AND SIGNATURE FORM

Employees driving company or personal vehicles on company business shall read or be trained on the following articles:

- Decision Driving
- Ten Defensive Driving Habits That Can Save Your Life
- 5 Characteristics of a Defensive Driver

Employees will sign below attesting that they have read and understood the information contained in the articles. A copy of this signed page, along with the articles, will be maintained in the employee's training file.

STATEMENT

I have read and understand the defensive driving information and recommendations contained in the named and attached articles. I understand that it is G4S Secure Solutions (USA) Inc.'s policy that I operate company vehicles and personal vehicles being driven on company business in accordance with the recommendations contained in these articles.

Shawn A. Wier

Printed Name:

12-01-2014

Date:

[Signature]

Signature:



Employee Name (Last, First, MI) Wieg, Shawn A	SSN (Last 4) [REDACTED]	Date of Hire 12-01-2014	Adj. Date of Hire
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PERSONNEL FILE CHECKLIST

(Items in BOLD indicate required documents)

☐ TSO	☒ USO	☐ CPO	☐ PRO	☐ Other: _____	☐ Overhead Employee
------------------------------	--	------------------------------	------------------------------	---------------------------------------	--

HRIS: **Hired** ☒ **Training Entered** ☒ **Licenses Entered** ☐ **Personnel Card** ☐

Section	Document	Initials
Pre-Offer Panel 1	FM-005 Application for Employment (Post 05/05/2013, 3 Parts: TribePad CV, ATS Personnel Info and Application)	JUP
	FM-078a Disclosure and Authorization to Obtain Consumer Report	JUP
	FM-170 Agreement Regarding Alcohol/Drug-Free Workplace Policy/Program and Related Drug/Alcohol Screening	JUP
Post-Offer Panel 1	FM-222a Conditional Offer of Site Assignment	JUP
	FM-222 Conditional Offer of Employment (Mandatory prior to 09/17/2012; optional thereafter.)	JUP
	Phase 2 Application Questionnaire (Printed from ATS or coupled with FM-222 above.)	JUP
	FM-028 Gun Control Act of 1968 Questionnaire (ARMED POSITIONS ONLY) (Must be completed annually.)	JUP
	Urinalysis/Drug Test Results (Results indicating a medical condition must be filed separate.)	JUP
	Background Preliminary: ☒ (Reviewed, Signed, and Dated by General Manager.) (May be replaced by Final.)	JUP
	Background Final: ☐ (Reviewed, Signed, and Dated by General Manager.)	JUP
	Proof of Education (e.g. DD214, High School diploma or transcript indicating completion of high school, GED, College degree/transcript, certified letter from State Department of Education, or background verification)	JUP
	Required Licenses (e.g. driver's security officer, armed security officer license.)	JUP
	Other Qualifying Documents:	JUP
Post-Hire (Policies and Procedures) Panel 2	FM-010c Personnel Action Change Form (as applicable)	JUP
	FM-010 New Hire Form	JUP
	W-4 Federal Tax Form ☒ State Tax Form (if applicable) ☐	JUP
	FM-013 Email Subscription Option Form	JUP
	FM-080 G4S Ethics Code Acknowledgement Form	JUP
	FM-015 Consolidated Acknowledgement and Consent Form (Completed upon hire and each December thereafter.)	JUP
	FM-057 Productivity Improvement Program	JUP
	FM-017a Commitment to Integrity	JUP
	FM-085 G4S PRIDE Acknowledgement Form	JUP
	FM-017b Your PID and Integrity (For current employees with a reissued PID)	JUP
	FM-017c PID Integrity - Branch Administration (For employees with Labor Scheduling System posting/correction access)	JUP
	FM-017d PID Integrity - Supervisory Personnel	JUP
	FM-017e Your PID and Integrity (New Employee) (For employees using automated check-in)	JUP
	FM-079 Non-Solicitation Agreement (if applicable)	JUP
	Fingerprint Card (if required; e.g., FM-209, FD 259)	JUP
	Other Required Legal Forms (e.g., meal and rest periods, state law, etc.)	JUP
	Other Contract Required Acknowledgement Forms (e.g., Confidentiality Agreements, Protective Vest, etc.)	JUP
Post-Hire (Training) Panel 3	FM-037 Training Checklist	JUP
	Training Certificates	JUP
	40-Hour Training Completion (e.g., graded examination forms) (for security personnel)	JUP
	Business Ethics and Compliance Training ☐ LM-88 (Level II employees) ☐ SPX-0104 (Level I employees)	JUP
	LM-09 Emergency Power Off Device Training Exam (for security personnel)	JUP
	Security Officer Handbook Exam (TR-3) (for security personnel)	JUP
	FM-234 Safety Handbook Acknowledgement and Consent Agreement	JUP
	FM-303a Safety Handbook Exam	JUP
	FM-234a Putting Safety First Motor Vehicle, Golf Cart and Bicycle Safety Receipt Form (for driving positions)	JUP
	FM-310 Off-Duty Training Request and Agreement Form	JUP
	CPR Card ☒ First Aid Card ☒ Automated External Defibrillator (AED) Card ☒	JUP
	FM-034 Youth Handgun Safety Act Receipt (ARMED POSITIONS ONLY) (Must be completed annually.)	JUP
	Other Required Forms (e.g., state required training, contract required training, etc.)	JUP

Section	Document	Initials	
Panel 3 (Cont.)	FM-1530 Acknowledgement of Guidelines for Safe and Secure Transport and Handling of G4S-Issued Guns (ARMED POSITIONS ONLY) (Must be completed annually.)		
	FM-1531 Gun Custodian Acknowledgement Form (Must be completed annually.)		
Post-Hire (Miscellaneous) Panel 4	FM-016 Personnel File Checklist	JWP	
	FM-621(a-f) Career Development Review (Annually - See POL-0621)		
	FM-023 Employee Disciplinary/Corrective Action Notice		
	FM-056 Attendance Irregularity Report Form		
	FM-126 New Employee Pay Selection Form / FM-126a Employee Pay Selection Change Form	JWP	
	FM-217 Direct Deposit Form / FM-217a Direct Deposit Cancellation Form	JWP	
	FM-060 Benefits Materials Acknowledgement Form (copy provided to employee)	JWP	
	Insurance Forms (forms indicating medical information must be filed separately)		
	Other: FM-125	JWP	
	Other:		
Separate Files	Pre-Offer	Basic Qualification Form (Printing not required after 09/17/2012 when stored in ATS)	JWP
		FM-007 Invitation to Self-Identify (Effective 03/24/2014, must have on file for paper applications)	JWP
		FM-007b Voluntary Self-Identification of Disability (Effective 03/24/2014, must have on file for paper applications)	JWP
	Post-Offer	EEO Data Sheet (FM-005a) (Pre-offer prior to 09/17/2012)	JWP
		FM-007a Invitation to Self-Identify (Post-Offer)	JWP
		FM-007b Voluntary Self-Identification of Disability (Post-Offer)	JWP
		☒ Completed Form I-9 (FM-192) ☒ Supporting Documents	JWP
		☒ E-Verify Employment Authorization (for those hired on or after September 8, 2009)	JWP
		Work Opportunity Tax Credit (WOTC) Documents/Confirmation Number (Form 8850, if required)	JWP
		FM-039 United States Military Service Questionnaire	JWP
		MMPI-2 and Results	
		Security Officer Profile (SOP) and Results (if required by contract)	
		Physical Examination Results	
		FM-018(a) Uniforms and Accessories Record (Return to Panel 2 of employee file upon employment termination.)	
		☐ FM-033 Weapon Receipt (if applicable) (Attach to FM-016.)	

Documents Provided to Employee via ATS Welcome Email*
FM-211 Sexual Harassment/Workplace Harassment Policy Statement
POL-250a Instructions for Employee Requests for Employment or Income Verifications
POL-250b Instructions for Third Party Requests for Employment or Income Verifications
401(k) Letter
FM-282 FMLA Notice of Rights and Responsibilities (DOL WHD 1420)
Supplemental Insurance Program Flyer
Employee Discount Program Flyer

*Office must provide the above documents to employee if not sent via the ATS Welcome email

Documents Provided to Employee by Local Office
Handbook(s): Security Officer ☒ Safety ☒
FM-056 Security Officer Plodge ☒
FM-060 Benefits Summary and Acknowledgement Form ☒
Employee Assistance Program Flyer ☒

For Non-Supervisory Personnel Assigned to a Site Covered by a Collective Bargaining Agreement (CBA)*
Union membership materials required by the CBA and provided by the union ☐
Union dues authorization card required by the CBA and provided by the union ☐

*If the employee gave a signed dues authorization form back to you, enter the employee's information on the required spreadsheet submitted to the Payroll Department for union dues

*Assign the individual to the job number for non-supervisory personnel working at that site

Initial Assignment Information				
Start Date	Site Assigned	(Full- or Part-Time)	Wage (Hourly/Annual)	Project ID
12/1/14	AGU	Full	10.50	
Management Review and Verification				
Background Investigation Summary Reviewed, Dated, and Initialed by General/Branch Manager: ☐				
Signature below indicates verification that file is complete. (One signed FM-016 is required per employee file.)				
General/Branch Manager Signature				Date



New Employee Pay Selection Form

(Applicable for employees hired on or after February 25, 2011.)

You have multiple options for receiving your pay. Please review the list below and mark your selection.

- ☐ _____ 1. ADP TotalPay Card & Money Network Check Program. By selecting this Program, I can use the following options available to me, which I can use together or independent of each other as described in the Welcome Kit.
- Initials
- A. Money Network Check. The Money Network Check is a self-issued paycheck that can be completed each payday morning. There is no waiting to pick up your Check. It is completed by phone wherever you may be. The Money Network Check can be deposited to your personal bank account or cashed for free at Money Network check cashing partners. There is no fee for using Money Network Checks at authorized locations.
- B. ADP TotalPay Card. The TotalPay debit card provides a dependable, safe and very convenient way to receive your pay. You can get your pay through ATM withdrawals, make purchases at stores, and get cash back with those purchases. You may also transfer money to a personal or joint checking account. You can hear your balance for free at any time by calling the toll free number on this debit card. Your pay will be available on payday morning, no matter where you are, and you can start spending it immediately. There is no waiting to get your check, and no waiting to cash your check; just use your card to start spending your money. Every employee is eligible for the TotalPay debit card. There is no application and no approval process. There is no monthly service charge for the debit card as long as you are employed by your current employer. Many debit card transactions are free but there are transaction fees for other transactions. Money Network Checks can also be used with your debit card account. All of the transaction fees are listed in your Welcome Kit. Please allow 10 business days for personalized card to reach you at your home address with valid zip code.
- ☒ SW 2. Direct deposit. I select direct deposit for disbursement of my pay. I hereby authorize my employer G4S Secure Solutions (USA) Inc. ("Company") to initiate deposits for my net pay to the financial institution I have designated ("Financial Institution") and further authorize Financial Institution to credit the account indicated with the deposits. If funds to which I am not entitled are deposited to my account, I authorize debits to my account and the return of such funds. This authority is to remain in effect until Company or Financial Institution has received notification from me of termination of such authorization in such time and such manner as to afford Company and Financial Institution a reasonable opportunity to act on those instructions or until Company or Financial Institution cancels the direct deposit arrangement. I understand that it may take 2 or 3 pay periods for this method to take effect. Until direct deposit takes effect, I understand that I will receive my pay through either a Company issued paycheck made payable directly to me or through a Money Network Check described above.
- Initials

I have attached a voided personal check and Direct Deposit Authorization Form FM-217.

This account is for (1) checking X or (2) savings _____

(Note that if cancelled check is attached, it is deemed to be for a checking account.)

I authorize G4S Secure Solutions (USA) Inc. to disburse my pay by direct deposit or to my TotalPay debit card account according to the selection I initialed above. I understand that if I do not make a selection above, I will be paid through the Money Network Check. I understand that I can change my pay selection to either of the above options at any time in the future using FM-126a Employee Pay Selection Change Form.

Print Name <u>Shawn A. Wier</u>	Signature <u>SWA m</u>	Last 4 Digits of SSN [REDACTED]	Today's Date <u>12-01-2014</u>	Date of Birth [REDACTED]
------------------------------------	---------------------------	------------------------------------	-----------------------------------	-----------------------------

Field Office: Retain the original(s) in the employee's personnel file. This is an automated process for new employees who have not designated a direct deposit account.

* * * Communication Result Report (Dec. 2, 2014 9:43AM) * * *

2}

Date/Time: Dec. 2, 2014 9:42AM

File No. Mode	Destination	Pg(s)	Result	Page Not Sent
0231 Memory TX	15616916687	P. 2	OK	

Reason for error

E. 1) Hang up or line fall

E. 3) No answer

E. 5) Exceeded max. E-mail size

E. 2) Busy

E. 4) No facsimile connection

E. 6) Destination does not support IP-Fax



DIRECT DEPOSIT AUTHORIZATION

Instructions: Complete this form and submit it to your supervisor to start using Direct Deposit, or to change or cancel an existing Direct Deposit arrangement. Please ensure that all of your personal and bank information is correct, and keep a copy of this form for your records. Please allow three pay periods from the date submitted to Corporate Payroll for processing.

1. EMPLOYEE INFORMATION

Employee Name: Shawn A. Wing (Last, First, Middle Initial)
 Address Line 1: 7234 Round River Drive
 Address Line 2: _____
 City: Granville, Ohio State: OH Zip: 43021-1219

2. BANK AND ACCOUNT INFORMATION

Enter the account information to authorize automatic deposits from your bank. Attach a voided check to this form. You are allowed to make deposits to up to 4 bank accounts. Use a separate form for additional accounts. If you are opening a new bank account, it is recommended that you open a new account at your financial institution with your new Social Security Number for Direct Deposit payments.

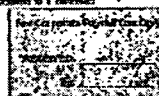
Bank Name	_____		
Bank Address	_____		
Branch	Attn: <u>HR</u>	Change ☐	Phone: _____
ACH Routing Number: _____			
ACH Account Number: _____			
Account Name	_____		
Pay to the Order of	_____		
Percent of Deposit	Direct Pay ☒	Percent of Pay ☐	Percent of Gross ☐
Specify Other Amount	\$ _____		

Attach a voided check from your bank to this form (not a separate document).

3. AUTHORIZATION

I authorize GAS to use my Social Security Number, together with the "GAS USA" logo, to electronically deposit my direct deposit into a checking or savings account at the bank named on this form. I understand that my signature may not be processed if it does not comply with the requirements for electronic deposits. I am fully responsible for submitting a Direct Deposit card to my supervisor as soon as possible. GAS USA assumes no responsibility for authorizing direct deposits to a non-existent bank account or to a non-existent branch.

Signature: Shawn A. Wing Date: 12-02-2014
 Printed Name: Shawn A. Wing Date: 12/1/14



Form 10/2010

Page 1 of 1



DIRECT DEPOSIT AUTHORIZATION

Instructions: Complete this form and submit it to your supervisor to start using Direct Deposit, or to change or cancel an existing Direct Deposit arrangement. Please ensure that all of your personal and bank information is correct, and keep a copy of this form for your records. Please allow three pay periods from the date submitted to Corporate Payroll for processing.

1. EMPLOYEE INFORMATION

Employee Name	Shawn A. Wier		SSN (last 4 digits only)	[REDACTED]
Address Line 1	7234 Roundstone Drive			
Address Line 2				
City	Blountville	State	SC	Zip Code 29829

2. BANK AND ACCOUNT INFORMATION

Ensure that all account information is complete. Incomplete forms will not be processed. Attach a voided check to this form. You are allowed to make deposits to up to 4 bank accounts. Use a separate form for additional accounts. If you are changing financial institutions, it is recommended that you maintain accounts at both financial institutions until your new financial institution receives the Direct Deposit payment.

Bank Name	[REDACTED]		
Bank Address	[REDACTED]		
Action: Add ☒ Change ☐	Account Type: Checking ☒ Savings ☐		
ACH Routing Number/Transit Number (always 9 digits) [REDACTED]			
(Please note that Routing Numbers beginning with the number 5 are invalid and will be rejected.)			
Account Number	[REDACTED]		
Amount to Deposit:	Branch Code		
Entire Net Pay ☒	[REDACTED]		
Percent of Net Pay ☐	[REDACTED] %		
Specific Dollar Amount ☐	\$ [REDACTED]		

Attach a voided check here
(not needed for savings accounts).

Your Name 1234 Oak Anytown, USA	1001		
PAY TO THE ORDER OF	\$ [REDACTED]		
Bank of America	DOLLARS		
ACH R/T 123456789			
FOR			
⑆ 1234 56789 ⑆ 000123456789 ⑆ 1001			
ACH Check/Routing Number 123456789	Account Number 000123456789	Check Number 1001	ACH Routing/Transit Number 123456789

3. AUTHORIZATION

I authorize G4S Secure Solutions (USA) Inc., hereinafter referred to as "G4S USA", to electronically deposit to the above account on a recurring basis until I notify G4S USA in writing that I revoke this authorization. Should any information be incomplete, or should I fail to attach a voided check, I understand that my request may not be processed. If I close or change bank accounts, I am fully responsible for submitting a Direct Deposit cancellation request as soon as possible. G4S USA assumes no responsibility for retrieving funds deposited to a canceled bank account due to failure to submit a cancellation request.

Employee Signature: [Signature] Date: 12-01-2014
Branch Approval Signature: [Signature] Date: 12/1/14

For Corporate Payroll Use Only

RECEIVED:

By:

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (last, first, middle initial) Wier, Shawn A		D TYPE OF DEPOSITOR ACCOUNT ☒ CHECKING ☐ SAVINGS	
ADDRESS (street, route, P.O. Box, APO/FPO) 7234 Roundstone Dr		E DEPOSITOR ACCOUNT NUMBER [REDACTED]	
CITY Graniteville	STATE SC	ZIP CODE 29029	
TELEPHONE NUMBER AREA CODE		F TYPE OF PAYMENT (Check only one) ☐ Social Security ☐ Fed. Salary/Mil. Civilian Pay ☐ Supplemental Security Income ☐ Mil. Active ☐ Railroad Retirement ☐ Mil. Retire. ☐ Civil Service Retirement (OPM) ☐ Mil. Survivor ☐ VA Compensation or Pension ☐ Other (specify)	
B NAME OF PERSON(S) ENTITLED TO PAYMENT		G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (if applicable) TYPE AMOUNT	
C CLAIM OR PAYROLL ID NUMBER Prefix Suffix			
PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		JOINT ACCOUNT HOLDERS' CERTIFICATION (optional) I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE		SIGNATURE	
DATE		DATE	
SIGNATURE		SIGNATURE	
DATE		DATE	

SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION USAA FEDERAL SAVINGS BANK 10750 McDERMOTT FREEWAY SAN ANTONIO, TX 78288-0544		ROUTING NUMBER [REDACTED]	CHECK DIGIT
		DEPOSITOR ACCOUNT TITLE	
FINANCIAL INSTITUTION CERTIFICATION I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.			
PRINT OR TYPE REPRESENTATIVE'S NAME Jeffrey P. Jensen	SIGNATURE OF REPRESENTATIVE [Signature]	TELEPHONE NUMBER 1-800-531-USAA (8722)	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

08101-1208

NSN 7540-01-058-0274

GOVERNMENT AGENCY COPY

1189-207

Designed using Perform Pro. WHS/GOR, Me-97



Employee Benefits Materials Acknowledgement Form

Employee Name: Shawn A. Wior

Last 4 Digits of SSN: [REDACTED]

A recent change in your employment status has resulted in a change to your employee benefits participation eligibility.

Qualifying Event Type:

☒ New Hire	☐ Primary Job Change	☐ Return from Leave of Absence (after maximum allowed days)
☐ Rehire (Less than 90 Days)	☐ Part-Time to Full-Time	☐ Open Enrollment
☐ Rehire (More the 90 Days)	☐ Full-Time to Part-Time	☐ Qualified Medical Child Support Order
☐ Other: (Please specify) _____		

Your local office has provided you with an Employee Benefits Package containing the following:

☒ Benefits Summary	☒ Enrollment/Change Form	☐ Summary Plan Description ("SPD")
☐ Medical History Statement Form (The Standard)		☐ Summary of Benefits Coverage ("SBC")
☐ Fully-Insured Medical Enrollment/Change Form		☐ Healthcare Exchange Notice

Remember:

- In order to enroll in your benefits plan, you must complete the Enrollment/Change Form and return the original to your G4S Secure Solutions (USA) Inc. Local Office ("your local office").
- You must enroll yourself in medical, dental, and/or vision benefits (as applicable) in order to enroll for dependant coverage under the corresponding plan.
- No changes will be permitted after your Initial Eligibility period until the next Open Enrollment period unless you have an eligible "Qualifying Event". In the event of an eligible "Qualifying Event," you have a maximum of 30 days to submit the required documents to your local office in order to enroll or make changes to your benefit elections. Please review "Your Group Benefits under Section 125" of the Internal Revenue Code in your Benefits Summary for more information.
- You will receive SPDs on a CD instead of paper unless you check the box below stating that you do not consent to receiving your SPDs on CD.
- All forms and plan booklets are available in paper form from your local office.
- Employee benefits are considered "contract-driven". This means that not all position assignments offer the same employee benefits coverage. When transferring assignments, it is your responsibility to request information pertaining to changes in your employee benefits. Your local office will be able to provide you with the most current information on all benefit packages. As with any eligible "Qualifying Event," a maximum of 30 days is allowed to submit the required documents to your local office in order to enroll. When your employment is terminated, all employee benefits are cancelled effective your date of termination.

I have received and read the materials for the employee benefits program for which I am entitled detailing my benefit options and the enrollment guidelines. I am aware of my benefit options and the date my benefits will become effective (only if I choose to enroll). I further understand the cost of my options, the Section 125 guidelines, the enrollment restrictions, and the deadlines for submitting enrollment forms and changes.

☐ I affirmatively consent to receive the SPDs for my benefit plans on CD. I have not withdrawn my consent and I understand that I may withdraw my consent at any time by notifying my local office. I affirm that I have access to a computer where I can view and/or print a copy of the SPDs. I understand I may request a free paper copy of any of the SPDs at any time by contacting my local office.

☒ I do not consent to receive the SPDs for my benefit plans on CD. I understand I will be provided with a free paper copy of the SPDs for my benefit plans.

Name: Shawn A. Wior

Signature: [Signature]

Date: 12-01-2014

Employer Use Only:	Area Office: <u>COL</u>
Benefit materials were distributed on: <u>12/1/14</u>	
Signature: <u>[Signature]</u>	Date: <u>12/1/14</u>



PAYROLL DEDUCTION FORM

Date: <u>12-01-2014</u>	Department Code: <u>COL</u>
Employee Name: <u>Shawn A. Wier</u>	Social Security Number (last 4 digits): <u>[REDACTED]</u>
Total Deduction Goal Amount: \$ <u>65.00</u>	
Deduction Amount of \$ _____ from wages earned, each pay period.	
Employees are advised to look for the deduction _____ on their next Earnings Statement. (license fee, payback, etc.)	
Reason for Deduction (check one): Registration/Licensing <u>SLED</u> (state) Other (explain) _____	

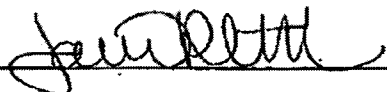
This authorization is given to G4S Secure Solutions (USA) Inc., or its subsidiaries, to deduct the above amount, advanced to me to for the purpose of enabling me to defray the costs associated with the above personal obligation. This authorization is wholly voluntary.

This deduction can be made from wages earned by me each pay period until the amount is paid in full. In the event I terminate my employment with G4S Secure Solutions (USA) Inc., or its subsidiaries, prior to repayment of the total sum, I authorize deduction of the remaining balance from any final pay due me if permissible. Otherwise, or in the event there are not sufficient funds due, I agree to pay the balance within thirty (30) days, and I waive my rights and concede judgment to G4S Secure Solutions (USA) Inc. for all amounts inclusive of legal costs required to obtain repayment.

Employee Name and Signature

Shawn A. Wier 

Authorized By Name,
Title and Signature

Jamie Proctor 

Payroll Representative
Name and Signature

Date

12/1/14

Estimated Completion Date

Mail
12/29/14

SOUTH CAROLINA
SECURITY OFFICER
[REDACTED]
IS REGISTERED
UNARMED
EXPIRES: 12/23/2015


Michael K. [Signature] CHIEF
S.C. Law Enforcement Division

VJMP



INVITATION TO SELF-IDENTIFY

THIS FORM IS TO BE FILLED OUT BY EMPLOYEE AT THE TIME OF HIRE.

G4S Secure Solutions (USA) Inc. is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

- A "disabled veteran" is one of the following:
 - o a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
 - o a person who was discharged or released from active duty because of a service connected disability.
- A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

As a Government contractor subject to VEVRAA, we are required to submit a report to the United States Department of Labor each year identifying the number of our employees belonging to each specified "protected veteran" category. If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

☒ I BELONG TO THE FOLLOWING CLASSIFICATIONS OF PROTECTED VETERANS (CHOOSE ALL THAT APPLY):

- ☒ DISABLED VETERAN
- ☒ RECENTLY SEPARATED VETERAN
- ☒ ACTIVE WARTIME OR CAMPAIGN BADGE VETERAN
- ☒ ARMED FORCES SERVICE MEDAL VETERAN

☐ I AM A PROTECTED VETERAN, BUT I CHOOSE NOT TO SELF-IDENTIFY THE CLASSIFICATIONS TO WHICH I BELONG.

☐ I AM NOT A PROTECTED VETERAN

If you are a disabled veteran it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations. This information will assist us in making reasonable accommodations for your disability.

Name <i>Shawn A. Wier</i>	Date <i>12-01-2014</i>
Signature <i>[Signature]</i>	Last 4 Digits of SSN [REDACTED]

It is the policy of G4S Secure Solutions (USA) Inc. to employ and advance in employment qualified disabled veterans, recently separated veterans, Active Wartime or Campaign Badge Veteran, and Armed Forces Service Medal veterans in accordance with their qualifications. Accordingly, our Affirmative Action Plan, revised and rewritten yearly, shall underscore our commitment. A copy of the Affirmative Action Plan is available for review in this office upon your request during regular working hours (8:30am to 5:00pm, Monday through Friday).

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017
Page 1 of 2

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.¹ To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

- ☐ YES, I HAVE A DISABILITY (or previously had a disability)
- ☐ NO, I DON'T HAVE A DISABILITY
- ☒ I DON'T WISH TO ANSWER

Shawn A. Wier

Your Name

12-01-2014

Today's Date



United States Military Service Questionnaire

Submission of this information is voluntary. The information you submit will be kept confidential and used solely for the purpose of measuring our success as a diverse and inclusive employer.

Employee Name:

Shawn A. Wier

Item 1

Do you presently serve, or have you served, as a member of the United States Military?

☒ Yes ☐ No ☐ I prefer not to provide this information

If yes, please move on to Items 2, 3, and 4.

If no, please skip Items 2 and 3, and answer Item 4.

Item 2

Please indicate your status:

☐ Active ☐ Inactive ☒ Retired ☐ Discharged

Item 3

Please indicate the Branch of Service (please check all that apply).

☒ Army	☐ Army Reserve	☐ Army National Guard
☐ Marine Corps	☐ Marine Corps Reserve	
☐ Navy	☐ Navy Reserve	
☐ Air Force	☐ Air Force Reserve	☐ Air National Guard
☐ Coast Guard	☐ Coast Guard Reserve	

Item 4

If married, is your spouse presently serving as a member of the United States Military?

☐ Yes ☒ No ☐ Not applicable

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

OMB No. 1545-1500

▶ See separate instructions.

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

Your name Shawn Allen Wier Social security number ▶ 
Street address where you live 7234 Roundstone Drive
City or town, state, and ZIP code Graniteville SC, 29829
County Aiken county Telephone number 757-867-3938
If you are under age 40, enter your date of birth (month, day, year) 

- 1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2 ☒ Check here if any of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but not age 40 or older and I am a member of a family that:
 - a Received SNAP benefits (food stamps) for the past 6 months, or
 - b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4 ☒ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months, or
 - Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, or
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

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

Job applicant's signature ▶



Date 12-01-2014

First Advantage

A Synovus Technology Group Company

Telephone Screening Guide Hiring Credits & Incentives

Today's Date:

12-01-2014

Employee/Applicant Name:

Shawn A Wier

Company: G4S Secure Solutions (USA), Inc

Location #: COL

Address: 1370 Browning Rd. Center Point 5, Columbia SC 29210

Location Primary Phone #: 803-256-7090

Location Email or Fax#: col.mail@usa.g4s.com



Attention Employee/Applicant:

G4S Secure Solutions USA, Inc., proudly participates in Employment Initiatives, including the Work Opportunity Tax Credit (WOTC). These initiatives promote the hiring of individuals who meet certain qualifications. An important part of our on-boarding process includes the completion of a brief employee phone screening administered by our partner, First Advantage. The information you provide during the screening is confidential and will only be used for the purpose of our company's hiring initiatives. This guide provides the necessary information for you to complete the screening process. Please write your information on the upper left portion of this form and follow the steps below. Thank You in advance, for your participation!

1.	Using the Company's telephone, dial 1-800-669-6000 <i>Please avoid using personal phones. If a company phone is not available and you must use a personal phone, you will be asked to enter the location primary phone number located above in order to complete the telephone screening.</i>	☒
2.	Confirm the name of your Employer (Company) by following the prompts <i>If the system is not able to confirm the name of your Employer, you will be transferred to a representative for assistance.</i>	☒
3.	Start the Tax Credit Screening by Pressing 1 and Enter your SSN accurately. <i>Your Social Security Number must be entered accurately to successfully complete the screening.</i>	☒
4.	Listen carefully and answer all questions that follow to the best of your knowledge. <i>If after answering all questions the system provides a Registration number ending on 5, please proceed to Step 7; otherwise please continue on to Step 5.</i>	☒
5.	If potentially eligible, you will be verbally presented with a statement indicating the information you provided is accurate to the best of your knowledge. In addition, you will be transferred to a representative for additional information. <i>By pressing 1 to agree, you will electronically sign and transmit a Form 8850 used to pursue WOTC. Complete Step 6 only if instructed by a representative. Please make sure you do not hang up as you are being transferred!</i>	☒
6.	If Instructed, check the box on the right and inform Manager to retrieve documentation requested by First Advantage immediately following your call	☒
7.	Write the Registration Number Provided at the end of the call below: 	☒

Attention Manager:

If Box 6 is checked, immediately following phone screening you will receive additional paperwork from First Advantage via email or fax to collect from employee and submit to First Advantage as soon as possible!

If you need assistance, please call 1-877-388-2256 or email taxsupport@fadv.com



New Hire Input Form

1

Instructions: Please complete all information except where noted.

Personal Data

Ceridian # Assigned (company use only):

Full Name: Wier, Shawn A.
(Last + Jr., II, etc., First, Middle Initial/name)

Preferred Name (Optional):

National ID No.:

Social Security Number (US):

Social Security Number (Canada):

National Identification Number (Other):

Home Address/Phone

Address 1: 2017 Harbors Circle

Address 2:

City: Granville State/Province: SC

Zip/Postal Code: 29829

County: Aiken

Country: United States

Home Phone:

Cellular Phone: 757-867-3938

Sex: Female ☐ Male ☒

Marital Status:

Common Law ☐

Divorced ☐

Separated ☐

Married ☒

Single ☐

Unknown ☐

Widowed ☐

Highest Education Level:

- ☐ Not Indicated
- ☐ Less than HG Graduate
- ☒ HS Graduate or Equivalent
- ☐ Some College/University/Trade
- ☐ Technical/Trade/Craft School (completed program)
- ☐ 1-2 Year College/University Degree (i.e., Associate Level)
- ☐ 3-4 Year College/University Degree (i.e., Bachelor's Level)
- ☐ Some Graduate/Masters School
- ☐ Masters Level Degree
- ☐ Doctorate/PHD (Academic - i.e., University Professor)
- ☐ Doctorate (Professional - i.e., Medical Doctor (MD), Dentists (DDS), Lawyer JD))
- ☐ Post-Doctorate

Birth date: Month Day Year

New Hire Input Form

2

Referral Source:

- ☐ Advertisement ☐ Job Posting
☐ Agency ☐ Other Source
☐ College Recruiting ☐ Unsolicited
☒ Employee ☐ Executive Search

Citizenship Status:

- ☒ US Native ☐ Alien Permanent
☐ US Naturalized ☐ Not indicated
☐ Alien Temporary (if Alien temporary, provide Visa Type: Visa #
Visa Start Date: Visa Expiration Date

Disabled: Yes ☐ No ☒

US Hires Only:

Disabled Veteran: Yes ☒ No ☐

Ethnic Group:

- ☒ White ☐ Asian/Pacific Islander
☐ Black ☐ American Indian/Alaska Native
☐ Hispanic ☐ Not Applicable (Non-US)

Military Status:

- ☐ Not Indicated ☐ Other Veteran ☒ Retired
☐ No Military Service ☐ Active Reserve
☐ Vietnam Era Veteran ☐ Inactive Reserve

Citizenship/Passport Data: (Country of birth/Naturalization)

Country: 2nd Country (if dual Citizenship)

Language Data: (Any language employee can speak, read or write)

For Native language "or able to Translate" indicate: Yes or No

For Speak/Read/Write choose one of the following: None, Low, Moderate, or High

Language Description	Native Language?	Able to Translate?	Speak	Read	Write

New Hire Input Form

3

Educational Data: (Any beyond High School/Equivalent where degree or certificate attained or near completion)

Degree: Year earned/expected:
Major: GPA: Graduated: Yes ☐ No ☐
School: State/Province: Country:

Degree: Year earned/expected:
Major: GPA: Graduated: Yes ☐ No ☐
School: State/Province: Country:

Primary Contact Name: *Wier, Amanda L.*
(Last, First, MI)

Primary Contact Home Address/Phone

Address 1: *2017 Honors circle*

Address 2:

City: *Glosterville* State/Province: *SC*

Zip/Postal Code: *29829*

County: *Aiken*

Country: *United States*

Home Phone:

Cellular Phone: *785-209-4965*

Primary Contact Relationship to Employee:

☒ Spouse ☐ Mother ☐ Father ☐ Sister
☐ Brother ☐ Son ☐ Daughter ☐ Other Relative
☐ Friend ☐ Neighbor ☐ Other

Secondary Contact Name:

(Last, First, MI)

Secondary Contact Home Address/Phone

Address 1:

Address 2:

City: State/Province:

Zip/Postal Code:

County:

Country:

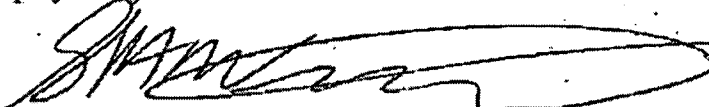
Home Phone:

Cellular Phone:

Secondary Contact Relationship to Employee:

☐ Spouse ☐ Mother ☐ Father ☐ Sister
☐ Brother ☐ Son ☐ Daughter ☐ Other Relative
☐ Friend ☐ Neighbor ☐ Other

Employee Signature:



New Hire Input Form

4

This Page is For Company Use Only

Employment/Job Data (Additional data to be supplied by Human Resources for Primary/Hourly or Staff/Salary employees in lieu of Job Change form)

Ceridian ID #: [REDACTED]

Clock # (if applicable): [REDACTED]

Union Code (if applicable):

Effective Date of Hire/Rehire: Month Day Year
4 28 15

Action & Reason

- ☒ Hire (New Hire)
☐ Hire (Rehire)
☐ Other, Please specify

☐ Regular or ☐ Temporary

☒ Full-time or ☐ Part-time

☐ Intern

Department #: 132 Department Name: Fab

Department Cost ID:

Job Code: Job Title: FSR

Home Job Code:

Shift Code: C

Seniority Department:

Location:

Company Code:

Employee Type: ☒ Hourly ☐ Salaried

Compensation Frequency: ☐ Annual ☐ Monthly ☐ Hourly

Compensation Rate:

IC Eligible Yes ☐ No ☐ % Amount

Job Earnings Distribution:

Account Code: Percent:
Account Code: Percent:
Account Code: Percent:
Account Code: Percent:

DATE OF HIRE: 4-28-15

No new employee hired by the company shall have tenure until he/she has completed a 120 day probationary period.

Shawn A. Wier
Employee Name

04-28-15
Date


Clock #

132
FSRB
C Shift


P
S



Employee Name: Shawna A. Wier
SS#: [redacted]

Position Offered: production

Date Examined: 4-23-15 Date of Birth: [redacted]

PRE-PLACEMENT & PERIODIC HISTORY AND PHYSICAL

Past Medical History: Do you have or have you ever had any of the following conditions?

#	Condition	Yes	No	Year
1	Active or recurrent infections		X	
2	Amputated foot, leg, arm, finger		X	
3	Asthma, chronic cough, shortness of breath or other lung problems	X		2009
4	Back pain, injury/surgery / problems	X		2011
5	Bleeding problems or blood thinner use			
6	Broken bone(s) or other injury with permanent impairment		X	
7	Chest pain		X	
8	Deafness or hearing difficulties		X	
9	Diabetes		X	
10	Ear, nose or throat problem		X	
11	Hand, foot, leg, knee, arm or shoulder, any joint problems	X		2011
12	Head or neck injury or condition: Migraines etc..	X		2011
13	Heart disease or surgery		X	
14	Hemorrhoids or rectal disease		X	
15	Hernia or hernia repair		X	
16	High blood pressure		X	
17	Illness or injury for which you see a physician regularly	X		2011
18	Kidney or bladder problems		X	
19	Liver problems		X	
20	Loss of sight, color blind or other eye problems		X	
21	Nervous or mental condition	X		2011
22	Seizures		X	
23	Any other medical issues		X	

#	Condition	Yes	NO	Year
24	Skin problem or rash		X	
25	Stomach problems		X	
26	Tuberculosis or positive TB skin test		X	
27	Have you ever been unable to hold a job because of: Sensitivity to chemicals, dust, latex, etc. Inability to perform certain motions Inability to assume certain positions Fear of closed spaces or heights. Any other medical problems		X	
28	Have you ever been exposed to: Excessive noise or worked in a job where hearing protection was required? Asbestos, silica, coke oven emissions or cotton dust? Hazardous chemicals Infected blood or body fluids?	X		2007-2014
29	Do you have any physical or mental condition(s) or restrictions which may prevent you from performing specific kinds of work or jeopardize your safety or the safety of your co-workers?		X	

See Pain management

no drugs not exposed

#21 - PTSD - seen VA mental health (Q22) #28 - did he know? (Q22)
#21 - exercise induced status pt. (Q22)

Explain items marked "Yes". Include number in left column. 1)

1) Asthma - exercise induced

(4, 11, 12, 17, 21, 28) military accident - head injury, neck and back injury, see doctors in augusta ga.

Shoulder, total back, foot complications - Field Pump (Q22)
Tongue Bcr fell on head in Auguston (Q22)
Injured by Veterans Admin. in Auguston.

Hospital Admissions/Serious Injuries: Include year you were injured or admitted to hospital and reason for admission or type of injury / surgery

Year	Illness/Injury/Operation	Year	Illness/Injury/Operation
2011	TMC - Field Hospital 9		
	Steps or hole then back to work as truck driver in malden (Q22)		

Medications: List all medications that you are now taking. Include over the counter medications

Name of Drug	Strength	How Often	Drug Allergies	Other Allergies
Paxil	40mg	Daily	"NKDA" (Q22)	"NKA" (Q22)
			Smoking History:	
			Do not smoke	Quit Smoking when?
			Current smoker	How many packs a day? 1/2
				How long have you smoked? 14 yrs (Q22)

Immunization: Please indicate the year of the last dose of each vaccine.

Tetanus / Diphtheria	2007 + 2011	Hepatitis B	2007 (Q22)	Influenza (Flu)	
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I certify that the above responses are true and complete. I hereby release AGY and its medical service contractors from any claims of liability as a result of providing or acting upon any information regarding me.

SIGNATURE: Shawna A. Wier

DATE: 04-23-2015

Reunited to patient Q22



2556 Wagener Road

NEW HIRE Production work

Name:

Shawn A. Wier

Date:

4/27/15

Time:

8:45 AM

☒ REVIEW Pre-Placement and Periodic History and Physical Questionnaire

☒ Physical Examination

☒ Vision Screening (including color vision)

☒ Audiometry

☒ PFT/Spirometry

☒ PA Chest X-ray

☐ PA Chest X-ray with B reader (if necessary)

☒ Urine Drug Screen

☐ EKG (if deemed necessary by Physician)

☐ Respiratory Questionnaire (if required to use respirator)

☐ Other

For CXR Registration

Name:

Shawn A. Wier

Address:

2017 honors circle

City:

Graniteville

Zip Code: 29829

DOB:

SS#:

Phone#: 757-867-3938



WWW.AGY.COM
AN EQUAL OPPORTUNITY EMPLOYER

EMPLOYMENT APPLICATION
HOURLY / PRODUCTION

unemployed

PERSONAL INFORMATION

NAME (LAST NAME, FIRST NAME): <u>Wier, Shawn</u>		SOCIAL SECURITY NUMBER: <u>[REDACTED]</u>	
ADDRESS <u>2017 honors circle</u>	APT. NO. <u></u>	CITY <u>Graniteville</u>	STATE <u>SC</u>
ARE YOU 18 YEARS OR OLDER? ☒ Yes ☐ No	PHONE: <u>757-867-3938</u>	EMAIL ADDRESS: <u>Shawn.wier@ymail.com</u>	

DESIRED EMPLOYMENT

POSITION (DO NOT leave blank) <u>FSR</u>	DATE YOU CAN START <u>04-17-2015</u>	SALARY DESIRED <u>\$17.50 hr</u>
ARE YOU EMPLOYED NOW? ☐ Yes ☒ No	IF SO MAY WE CONTACT YOUR PRESENT EMPLOYER? ☐ Yes ☐ No	
HAVE YOU EVER APPLIED TO AGY BEFORE? ☒ Yes ☐ No	WHERE? <u>Aiken</u>	WHEN? <u>January, 2015</u>
HAVE YOU EVER BEEN EMPLOYED BY AGY? ☐ Yes ☒ No		
IF YES, PLEASE SPECIFY LOCATION AND DATE:		
WHO REFERED YOU TO AGY? ☐ EMPLOYEE REFERRAL (NAME _____) ☒ WWW.AGY.COM ☐ NEWSPAPER ADVERTISING ☐ SC ONESTOP CENTER ☐ OTHER LIST SOURCE		

EDUCATION

SCHOOL LEVEL	NAME AND LOCATION OF SCHOOL	NO. OF YEARS ATTENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
HIGH SCHOOL	<u>Ocean Lakes</u>	<u>2</u>	<u>no</u>	
COLLEGE				
TRADE, BUSINESS OR CORRES. SCHOOL				

GENERAL

SPECIAL TRAINING - List any special training you received <u>Basic combat Training, Advanced individual training, weapons leader course, Retention course, Security</u>					
SPECIAL SKILLS If skilled, craft, or both, list skill and number of years of full-time experience					
1. <u>Management</u> Skill	<u>2</u> Years	2. <u>Heavy vehicle operator</u> Skill	<u>7</u> Years	3. <u>Mechanic</u> Skill	<u>7</u> Years

Updated January 2015

EMPLOYMENT: Please complete fully starting with your most recent position. List all employment of three months or more during the last 10 years. Listing "refer to resume" will not be sufficient.

NAME OF PRESENT OR LAST EMPLOYER: <i>GYS</i>		TEMP AGENCY NAME, IF APPLICABLE:	
ADDRESS <i>1370 Blowing Rock Rd #110</i>		CITY <i>Columbia</i>	STATE <i>SC</i> ZIP <i>29210</i>
STARTING DATE <i>12-01-14</i>	LEAVING DATE <i>01-21-15</i>	JOB TITLE <i>Site Supervisor</i>	
STARTING PAY <i>10.50</i> Hourly ☐ Annually	FINAL PAY <i>10.50</i> Hourly ☐ Annually	MAY WE CONTACT YOUR SUPERVISOR? ☒ Yes ☐ No	
NAME OF SUPERVISOR <i>Maj. Lewis</i>		TITLE <i>Area Supervisor</i>	PHONE <i>803-250-7090</i>
DESCRIPTION OF WORK <i>Security guard, Supervisor, Training, managed schedules of subordinates</i>			
REASON FOR LEAVING <i>No room for progression</i>			

NAME OF PRESENT OR LAST EMPLOYER: <i>U.S. Army</i>		TEMP AGENCY NAME, IF APPLICABLE:	
ADDRESS		CITY <i>Fort Hood</i>	STATE <i>TX</i> ZIP <i>76544</i>
STARTING DATE <i>04-05-2007</i>	LEAVING DATE <i>09-14-2014</i>	JOB TITLE <i>Squad leader</i>	
STARTING PAY ☐ Hourly ☐ Annually	FINAL PAY ☐ Hourly ☐ Annually	MAY WE CONTACT YOUR SUPERVISOR? ☐ Yes ☒ No	
NAME OF SUPERVISOR		TITLE	PHONE
DESCRIPTION OF WORK <i>Maintained log books and mileage of equipment</i>			
<i>Supervised and managed subordinates, Accountability of personnel and equipment</i>			
REASON FOR LEAVING <i>Medical Retirement</i>			

NAME OF PRESENT OR LAST EMPLOYER:		TEMP AGENCY NAME, IF APPLICABLE:	
ADDRESS		CITY	STATE ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
STARTING PAY ☐ Hourly ☐ Annually	FINAL PAY ☐ Hourly ☐ Annually	MAY WE CONTACT YOUR SUPERVISOR? ☐ Yes ☐ No	
NAME OF SUPERVISOR		TITLE	PHONE
DESCRIPTION OF WORK			
REASON FOR LEAVING			

LIST THREE PROFESSIONAL REFERENCES WHO ARE NOT RELATED TO YOU

	NAME	TITLE	PHONE NUMBER	YEARS KNOWN
1	Michael Nixon	Squad leader	254-319-7837	3
2	Johnelle Brown	Squad leader	254-368-2616	5
3	Joe Smith	Squad leader	931-220-2090	5

SERVICE RECORD

RANK OR SERVICE	DISCHARGE DATE
United States Army	09-14-2014 SGT/E-5

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ☐ Yes ☒ No

IF YES, PLEASE EXPLAIN (WILL NOT NECESSARILY EXCLUDE YOU FROM CONSIDERATION)

ONLY U.S. CITIZENS OR ALIENS WHO HAVE A LEGAL RIGHT TO WORK IN THE U.S. ARE ELIGIBLE FOR EMPLOYMENT. CAN YOU, UPON EMPLOYMENT PROVIDE GENUINE DOCUMENTATION ESTABLISHING YOUR IDENTITY AND ELIGIBILITY TO BE LEGALLY EMPLOYED IN THE UNITED STATES? ☒ Yes ☐ No

HAVE YOU EVER BEEN DISCHARGED FROM ANY EMPLOYMENT OR ASKED TO RESIGN? ☒ Yes ☐ No

IF YES, PLEASE EXPLAIN: Medical Retirement from U.S. Army

AUTHORIZATION

I certify that the answers given herein are true and complete to the best of my knowledge. I also authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written documentation or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Employer.

04-14-2015
DATE

[Signature]
SIGNATURE

AGY HOLDING CORP. IS AN EQUAL OPPORTUNITY EMPLOYER. APPLICANTS WILL RECEIVE CONSIDERATION FOR POSITIONS, WITHOUT REGARD TO RACE, COLOR, RELIGION, AGE, SEX, EXCEPT WHERE SEX IS A BONA FIDE OCCUPATIONAL QUALIFICATION, SEXUAL ORIENTATION, MARITAL STATUS, INDIVIDUALS WITH DISABILITIES, AND EQUALLY TO DISABLED VETERANS AND VETERANS OF THE VIETNAM ERA.

Check Detail - Current Hours / Earnings ADVANCED GLASSFIBER YARNS

Date Range 04/28/2015 to 09/01/2015
Report Date 09/01/2015

VRX - Aqv Aiken Llc

Name	Clock No	Check No	Check Date	Pay Code	Current Hours	Current Earnings
WIER, SHAWN A.		976415	07/09/2015	1	32.00	573.44
		976415		2	0.00	0.00
		976415		5	0.00	0.00
		976415		SH	0.00	0.00
		A207797	05/07/2015	1	44.00	763.40
		A207797		1	0.25	4.46
		A207797		5	0.25	2.23
		A207797		5	4.00	34.70
		A208312	05/14/2015	1	31.75	568.98
		A208312		1	16.25	284.70
		A208312		5	0.25	2.19
		A208312		5	7.75	69.44
		A208836	05/21/2015	1	16.00	288.32
		A208836		1	24.00	430.08
		A208836		5	0.00	0.00
		A209365	05/28/2015	1	0.25	4.48
		A209365		1	39.00	702.78
		A209365		5	0.00	0.00
		A209901	06/04/2015	1	8.00	143.92
		A209901		1	0.50	9.25
		A209901		1	32.00	560.64
		A209901		1	1.50	27.58
		A209901		5	1.50	13.80
		A209901		5	0.50	4.62
		A210425	06/11/2015	1	17.00	305.83
		A210425		1	3.00	55.47
		A210425		1	20.00	367.80
		A210425		5	3.00	27.74
		A210425		5	5.00	45.98
		A210425		5	1.00	8.99
		A210945	06/18/2015	1	16.00	288.32
		A210945		1	8.00	143.36

Check Detail - Current Hours / Earnings

ADVANCED GLASSFIBER YARNS

Date Range 04/28/2015 to 09/01/2015
Report Date 09/01/2015

VRX - Agy Aiken Llc

Name	Clock No	Check No	Check Date	Pay Code	Current Hours	Current Earnings
		A210945	06/18/2015	5	0.00	0.00
		A211451	06/25/2015	1	1.50	26.88
		A211451		1	31.75	572.14
		A211451		5	1.25	11.20
		A211959	07/02/2015	1	41.00	718.32
		A211959		1	2.00	36.04
		A211959		1	8.00	143.36
		A211959		5	8.00	70.08
		A211959		5	1.00	8.96
		A211959		5	2.00	18.02
		A212499	07/09/2015	1	18.75	328.50
		A212499		1	2.00	36.04
		A212499		1	24.00	430.08
		A212499		2	8.00	140.16
		A212499		5	1.75	15.33
		A212499		5	2.00	18.02
		A212499		5H	1.00	8.76
		A212499		5H	8.00	71.68
		A213024	07/16/2015	1	16.00	288.32
		A213024		1	0.25	4.38
		A213024		1	24.50	439.04
		A213024		2	0.00	0.00
		A213024		5	0.25	2.19
		A213024		5	0.50	4.48
		A213024		5H	0.00	0.00
		A213542	07/23/2015	1	39.75	716.30
		A213542		1	0.50	8.96
		A213542		2	0.00	0.00
		A213542		5	0.25	2.24
		A213542		5H	0.00	0.00
		A214051	07/30/2015	1	39.00	683.28
		A214051		2	0.00	0.00
		A214051		5	0.00	0.00

Check Detail - Current Hours / Earnings
ADVANCED GLASSFIBER YARNS

Date Range 04/28/2015 to 09/01/2015
 Report Date 09/01/2015

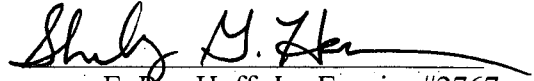
VRX - Agy Aiken Lic

Name	Clock No	Check No	Check Date	Pay Code	Current Hours	Current Earnings
		A214051	07/30/2015	5H	0.00	0.00
		A214586	08/06/2015	1	31.50	584.48
		A214586		1	16.50	289.08
		A214586		2	0.00	0.00
		A214586		5	7.50	67.20
		A214586		5	0.50	4.38
		A214586		5H	0.00	0.00
		A215101	08/13/2015	1	0.25	4.38
		A215101		1	24.00	430.08
		A215101		1	16.00	298.32
		A215101		2	0.00	0.00
		A215101		5	0.25	2.19
		A215101		5H	0.00	0.00
		A215607	08/20/2015	1	39.50	711.79
		A215607		1	1.00	17.92
		A215607		2	0.00	0.00
		A215607		5	0.50	4.48
		A215607		5H	0.00	0.00
		A216117	08/27/2015	1	6.00	105.12
		A216117		2	0.00	0.00
		A216117		5	0.00	0.00
		A216117		5H	0.00	0.00
Totals For WIER, SHAWN A.					759.25	13,024.66
Totals For VRX - Agy Aiken Lic					759.25	13,024.66

Certificate of Counsel

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and no other material.

June 15, 2017



E. Ros Huff, Jr., Esquire #2767

Shelby G. Hapeshis, Esquire #74731

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