YOUR ALL TEAM OFFICES

Since 1989

Food Team, RIF, Med Team, All Team

SAN DIEGO BRANCH

3505 Camino Del Rio South, Suite 350
San Diego, California 92108
Office: (619) 704-0970
Fax: (619) 704-0977
On-Call Cell: (619) 806-2080

VISTA BRANCH

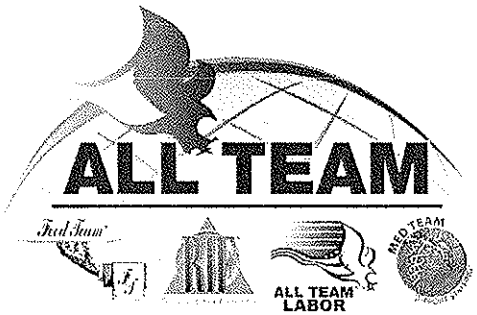
380 South Melrose Drive, Suite 102
Vista, California 92081
Office: (760) 295-4447
Fax: (760) 295-4450
On-Call Cell: (619) 888-5999

LOCAL CONTACTS

Director of Operations – Scott Colvin
Director of Staffing – James Daniels
Staffing Manager – Erik Ong
Staffing Manager – Lisa Podrup
Staffing Manager – Anne Marie Roberts, Vista Branch
Accounts Receivable – Bonnie Osterhage
Payroll Administrator – Glenda Castillo
IT Manager – Cory Green

For More Information:

www.allteamcompanies.com
www.servicestaffsandiego.com



STAFFING AGREEMENT

This Staffing Agreement is made and entered into on _____/_____/_____ by and between All Team Staffing and _____ (Client). Client wishes to retain All Team Staffing for the purpose of providing temporary and permanent personnel to work at site(s) designated by Client.

Scope of Services

1. All Team shall recruit; screen, test and reference check all personnel performing work assignments through All Team for Client.

2. All Team shall be responsible for all wages, taxes and insurance liability associated with All Team employees. Each worker will be covered under a general liability policy as well as a workers compensation policy.

3. All Team shall adhere to all federal, state and county laws regarding completion of I-9 and W-4 information for each employee sent to Client.

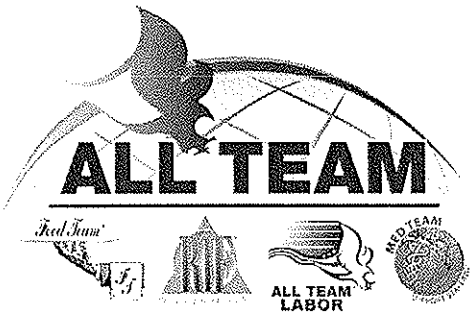
4. All Team shall schedule the correct number of employees based on Client's needs. All Team reserves the right to overbook for orders of more than 10 people by up to 10%. If, when overbooking, Client should not need the excess employee(s), All Team shall bear the cost of the excess employee(s) scheduled. However, if Client wishes to use the excess employee(s), they shall be billed at the appropriate rate.

5. All Team shall submit weekly to Client, an invoice containing at a minimum the following: week-ending date or date of work completed, employee names, bill rate, and correct hours for each employee. Billing is based on a workweek beginning Monday and ending Sunday.

6. All Team shall adhere to the employee standards set by Client. If for any reason, an employee does not meet the standards set by client, a notification to All Team must be made within the first 2 hours of the shift and All Team will find a replacement employee immediately upon request.

Client Agreements

1. Client agrees to work All Team employees a minimum of 4 hours for each scheduled shift, provided employee is on time and in proper uniform.



2. Client agrees to pay for all hours worked in a given week. Workweeks will begin on Monday and end on Sunday. Hours worked over 40 are billed at billing rate times 1.5 and hours worked over 60 are billed at billing rate times 2. The following days, New Years Day, Easter, Mother's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve, Christmas Day and New Years Eve will be billed at billing rate times 1.5.

3. Client agrees to give ample notice in the case of a cancellation. For single person orders, this must be done at least 4 hours prior to the beginning of a shift. For multiple person orders, cancellation must be 24 hours prior to scheduled shift. For orders of 25 or more, at least 48 hours notice must be given. All Team reserves the right to charge client the 4-hour minimum for each employee if cancellation is not received with ample notice.

4. Client agrees that Employees sent by or referred by All Team offices, in the past and during the term of this agreement, are All Team employees, and remain All Team employees. Any employee sent by All Team shall remain an All Team referral for a period of 6 months following the last date worked with Client. Any employee hired by Client either directly or indirectly within those 6 months shall be billed at 100 times bill rate.

5. Should Client find an employee that does not meet the standards set, Client will immediately notify an All Team representative. Client will not be responsible for billing of that particular employee for the day.

6. Client agrees to pay for services rendered within 30 days of invoice date. Any discrepancies with invoices shall be addressed within 10 days of invoice date by fax 619-704-0977 attn: Lisa Podrup or e-mail to lisa@servicestaffsd.com. Receipt of discrepancy will be addressed within one business day. Any undisputed invoice not paid within 45 days will be assessed a 5% service charge at 45 days and accrue interest at a rate of 1.5% per month thereafter. Any invoice forced into collections will be billed an additional flat rate for collections of 33.3%. All collection fees, court costs, attorney fees, etc. shall be added to the invoice total and be paid by client.

Billing Rates and Conversions

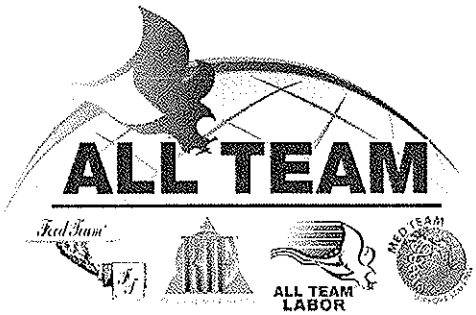
1. Client shall be billed the following hourly rates for each position listed:

_____

_____

_____

Unlisted positions will be negotiated prior to assignment.



2. Client may only hire directly with no additional fee any employee who has completed 520 hours, within a 6-month period.

3. Should client wish to convert an employee prior to 520 hours, the conversion rate shall be hourly billing rate times 100. Hours worked previously will be deducted by percentage of 520 hours. Client shall notify All Team the week prior to converting an employee.

IN WITNESS WHEREOF, the parties have executed this agreement on this the _____ day of _____, 20___.

All Team Staffing

By: _____

Signature: _____

Title: _____

Address:
3505 Camino Del Rio S, Suite 350
San Diego, CA 92108

Client:_____

By: _____

Signature: _____

Title: _____

Address:
_____
_____

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
Service Staff, Inc.

Business name/disregarded entity name, if different from above
All Team Labor Staffing, Food Team Staffing, Med Team Support Staffing

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☑ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Exempt payee

☐ Other (see instructions) ▶

Address (number, street, and apt. or suite no.)
3505 Camino Del Rio S, Suite 350

Requester's name and address (optional)

City, state, and ZIP code
San Diego, CA 92108

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			-			-				

Employer identification number

7	1	-	1	0	3	7	3	8	9

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ [signature] Date ▶ 2-20-2012

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

OP ID: PP

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/10/12

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER CTK North American Insurance Services, LLC 1240 N Lakeview Ave, Suite 240 Anaheim, CA 92807 Judy Steckman 714-779-2000 714-779-4129	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: PRODUCER CUSTOMER ID #: FOODT-1
INSURED Service Staff, Inc. dba: Food Team, All Team Med Team Support Staffing 3505 Camino Del Rio South #350 San Diego, CA 92108	INSURER(S) AFFORDING COVERAGE / NAIC # INSURER A : Praetorian Insurance Company 37257 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC			H67-1001836-00	09/26/11	09/26/12	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ see PROP $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [ ] HIRED AUTOS [ ] NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	[ ] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DEDUCTIBLE [ ] RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

SAMPLEC

**********SAMPLE**********
*********CERTIFICATE**********
IF JOB IS AWARDED, CERTIFICATE WILL BE ISSUED UPON REQUEST
**********, ** **********

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Richard D. Siemer

Food Team, Inc
Credit Card
Authorization

PLEASE PRINT

FT Rep: _____

Client # : _____

Client : _____

Address : _____

City : _____

State : _____ Zip : _____

Card Type : _____

Account # : _____

Expiration Date : _____

CVV2 - 3 - 4 digit number on back of card _____

Is this card a corporate card or personal (Must answer) _____

If no invoice has been generated estimate the amount of the charge for approval

Inv # :_____ $ Amt :_____

I, _____ (Cardholder) authorize Food Team to charge my credit card for the amount stated above for service rendered or services to be rendered.

Signature _____

Date _____