

## DEPARTMENT OF LABOR AND TRAINING

Workshare Unit PO Box 20310 Cranston, RI 02920-0943

Mailing date:

October 1, 2003

Workshare Plan#: WS-100000-01

WS-100000-01 0000123456

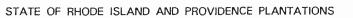
Emp Reg No: Unit Name:

PRODUCTION

1 MAIN STREET
ANYWHERE, R.I. 02901

ABC COMPANY INC.

	Location of Worksharing, if different than above:						
	Specific type of business:						
3. 4.	On what date (must be a Sunday) do you want this plan to begin?						
	PLEASE LIST THE PARTICIPANTS FROM THE AFFECTED UNIT ON THE ATTACHED PARTICIPANT LISTING.						
5.	Will fringe benefits be affected?YESNO If Yes, please explain						
6.	What percentage are the normal weekly hours of work and wages reduced?						
7.	Is the reduction spread equally among employees in the affected unit? YESNO						
8.	What is the reason for the expected work reduction?						
9.	Worksharing covers only full time employees. Seasonal workers are not eligible.						
10.	In order to participate in the Worksharing program, the employer must agree to allow the Director or authorized representative access to all records pertaining to employer/employee eligibility and permit monitoring and evaluation of the project.						
11.	Are any employees who will participate in this plan covered by a collective bargaining agreement?						
	YESNO If Yes, please identify the union and have the authorized representative sign the form below indicating union concurrence.						
	Union Name:Local No.:						
	Agent Signature: Date:						
	IF AFFECTED EMPLOYEES ARE NOT COVERED BY A BARGAINING UNIT, THE PLAN MUST BE EXPLAINED TO EMPLOYEES PRIOR TO SUBMITTING THIS APPLICATION.						
12.	The following person may be called for further information: (Contact Person)						
	Name: Phone No.:						
	Employer Certification: I certify that the answers and information that I have provided for approval of this plan are complete, true, and correct.						
	THIS REPORT MUST BE SIGNED BY THE OWNER, A PARTNER, A CORPORATE OFFICER OR DULY AUTHORIZED EMPLOYER REPRESENTATIVE.						
	Signature: Title: Date:						
	The Director will approve this plan in writing approximately 15 working days upon receipt by the Department. The Director may revoke an approved worksharing plan for good cause. The determination is first and non-appealable. An employer whose request was depied may submit another plan for						





## DEPARTMENT OF LABOR AND TRAINING

Workshare Unit PO Box 20310 Cranston, RI 02920-0943

Employee Name	Social Security Number	Normal Hours of Work Per Week
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		





## DEPARTMENT OF LABOR AND TRAINING

Workshare Unit PO Box 20310 Cranston, RI 02920-0943 WORKSHARE BIWEEKLY CLAIM FORM

Mailing date: October 1, 2003

Workshare Plan#: WS-100000-01

Emp Reg No: 0000123456

Unit Name:

PRODUCTION

ABC COMPANY INC.

1 MAIN STREET

ANYWHERE, R.I. 02901

AFFECTED UNIT -01- PRODUCTION

MAIL OR FAX THIS FORM AFTER October 18, 2003

EMPLOYER NAME	SOCIAL SECURITY NUMBER	UNAPPROVED I	LEAVE/SICK LEAVE	# HOURS WORKED incl APPROVED/HOLIDAY/VAC/PERS LEAVE		
WEEKENDING DATES		10/11/03	10/18/03	10/11/03	10/18/03	
JOHN DOE	111-11-1111/04			32	32	
JANE SMITH	101-22-1234/04			32	3 2	
ROBERT JONES	201-23-4567/04		1.	32	31	
MARY HALL	001-99-0909/04			38	32	
		LOCAL MARKET				
**						
94						
		···				
		w				

WORKSHARE	EMPLO	YFR· I	CERT	FY TH	AT T	HE IN	DIVID	UALS	LISTE	D ABO	VE AC	CEPTED	ALL	WORKED
DFFERED AN	D THAT	THEIR	REDU	CTION	IN H	OURS	WAS	AS ST	TATED	IN TH	E APPI	ROVED	<b>WORK</b>	SHARING
DI AN 120 %	) ANY	EXCEP	PTION	S TO	THE	HOUR	IS IN	THE	PLAN	HAVE	BEEN	INDIC	ATEC	) NNDFR
JNAPPROVED	LEAVE/	SICK LE	EAVE.	THE IN	<b>IFORM</b>	IOITAI	I FURI	VISHED	ON T	HIS FO	RM IS	TRUE A	ND C	ORRECT.

SIGNATURE/TITLE	DATE	PHONE#	
-----------------	------	--------	--