STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

# DEPARTMENT OF LABOR AND TRAINING

Workshare Unit
PO Box 20310 Cranston, RI 02920-0943

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

1. Location of Worksharing, if different than above:_____
2. Specific type of business:_____
3. On what date (must be a Sunday) do you want this plan to begin?_____
4. Affected Unit:_____ No. of Employees in Unit:_____

   PLEASE LIST THE PARTICIPANTS FROM THE AFFECTED UNIT ON THE ATTACHED PARTICIPANT LISTING.
5. Will fringe benefits be affected? ___YES ___NO 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? ___YES ___NO
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?
    ___YES ___NO 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 final and non-appealable. An employer whose request was denied may submit another plan for

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

# 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. | | |
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| 16. | | |
| 17. | | |
| 18. | | |
| 19. | | |
| 20. | | |
| 21. | | |
| 22. | | |
| 23. | | |
| 24. | | |

WSCIM (2/02)

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

# 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 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 | 32 |
| ROBERT JONES | 201-23-4567/04 | | 1 | 32 | 31 |
| MARY HALL | 001-99-0909/04 | | | 32 | 32 |
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WORKSHARE EMPLOYER: I CERTIFY THAT THE INDIVIDUALS LISTED ABOVE ACCEPTED ALL WORKED OFFERED AND THAT THEIR REDUCTION IN HOURS WAS AS STATED IN THE APPROVED WORKSHARING PLAN ( 20 %). ANY EXCEPTIONS TO THE HOURS IN THE PLAN HAVE BEEN INDICATED UNDER UNAPPROVED LEAVE/SICK LEAVE. THE INFORMATION FURNISHED ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE/TITLE_____DATE_____PHONE#_____