



Discharge – SLEEPING ON THE JOB

Please answer all questions below. Any questions left unanswered WILL NOT be considered when determining your eligibility for Unemployment Insurance.

Claimant Name: _____

Last 4 Digits of your Social Security #: _____ Date completing questionnaire: _____

Claimant Statement

1. What was your last physical date of work (mm/dd/yyyy)? _____

2. When were you fired/discharged (mm/dd/yyyy)? _____

3. Who discharged you? Name: _____

Title: _____

4. What specific reason did the employer give you for being discharged?

5. Were you sleeping on the job? YES NO

a. If yes, how was this determined? Eyes Closed Head Down Lying Down Other

If other, please specify: _____

b. If no, why did your employer feel that you were sleeping on the job?

6. Has there been a prior incident or incidents where you slept on the job? YES NO

If yes, please provide details and dates of prior incidents:

If yes, were you previously warned for any prior act of sleeping on the job? YES NO

If yes, provide date of warning (mm/dd/yyyy): _____

i) Type of Warning: Verbal Written Final

ii) Provide details of last warning:

iii) Name and title of person who issued the last warning:

Name: _____

Title: _____

Rhode Island Department of Labor and Training
Unemployment Insurance - Central Adjudication Unit
P.O. Box 20067, Cranston, RI 02920 | Fax: 401-462-8318

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7. Does the employer have a policy regarding sleeping on the job? YES NO
If yes, were you aware of this policy? YES NO
If yes, what is your understanding of this policy?

How were you notified of the policy?

- Bulletin Board Email Handbook/Handout
 Verbally Video Not Informed

8. Provide details of any other warnings you were issued. Include the dates and the name of the individual(s) who issued the warning(s). If you did not have any prior warnings, indicate "None".

9. Enter any additional information you feel may be necessary:

I hereby certify that, to the best of my knowledge and belief, the information I have provided is true. YES NO

Signature: _____