



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
 DEPARTMENT OF LABOR AND TRAINING  
**Workshare Unit**  
 PO Box 20310, Cranston, RI 02920-0943  
 TTY Via RI Relay 711

Mailing Date: _____
Workshare Plan #: _____
Emp Reg No: _____
Unit Name: _____

1. Location of Worksharing, if different than above: \_\_\_\_\_
2. Specific type of business: \_\_\_\_\_
3. Indicate the estimated number of layoffs which will be averted by participation in the WorkShare program. \_\_\_\_\_
  - a. What percentage of staff in affected units does this number represent? \_\_\_\_\_%
4. On what date (**must be a Sunday**) do you want this plan to begin? \_\_\_\_\_
5. How and when will affected employees be notified of WorkShare participation? If no advance notice is given, please indicate the reason:

PLEASE NOTE: EMPLOYEES MUST BE PROVIDED ADVANCE NOTICE OF PARTICIPATION WHENEVER FEASIBLE

6. Affected Unit: \_\_\_\_\_ Number of Employees: \_\_\_\_\_  
 PLEASE LIST THE PARTICIPANTS FROM THE AFFECTED UNIT ON THE ATTACHED PARTICIPANT LISTING

7. What percentage are the normal weekly hours of work reduced? \_\_\_\_\_%

8. Will fringe benefits be affected?  Yes  No

a. If yes, please specify which benefits and how they will be affected:

9. Is the reduction spread equally among employees in the affected unit?  Yes  No
10. What is the reason for the expected work reduction? \_\_\_\_\_

**IMPORTANT: State Statute relative to workshare does not allow for participation during normal seasonal fluctuations in business. Workshare covers only Permanent Employees. Seasonal, temporary and/or intermittent employees are not eligible.**

In order to participate in the WorkShare program, the employer must agree to allow authorized representatives of the Director 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
12. If Yes, please identify the union and have the authorized representation sign the form below indicating union concurrence.

Union Name: \_\_\_\_\_ Local Number: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

13. Is participation in the WorkShare program as defined in this plan consistent with your company's obligations under all Federal and State laws?  Yes  No

If no, please explain: \_\_\_\_\_

14. The following person may be called for further information (Contact Person):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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 a duly authorized employer representative.**

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

The Director will approve this plan in writing in approximately 15 working days upon receipt by the Department. The Director may revoke an approved WorkShare plan for good cause. The determination is final and non-appealable. An employer whose request was denied may submit another plan for approval.