



Voluntary Quit – CARE FOR ILL/DISABLED FAMILY MEMBER

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. What was your date of separation (if different from your last day of work - mm/dd/yyyy)? _____
3. Did you provide notice to your employer that you were leaving? YES NO a. If no, why didn't you provide a notice?

b. If yes, whom did you notify? Name: _____

Title: _____

c. When did you provide the notice (mm/dd/yyyy)? _____

d. How much notice did you give your employer? _____

e. Did your employer allow you to work out your notice? YES NO

If no, what reason was given for not allowing you to work out your notice?

If you were not allowed to work out your notice, did your employer pay you for the remainder of your notice? YES NO

If yes, please indicate the amount of money paid to you for the remainder of your notice. \$ _____

4. Why did you leave this job?

5. Did you inform your employer that the reason stated in Answer #4 was the reason for leaving? YES NO

If no, what reason did you give your employer for leaving?

6. What is the relationship of the ill/disabled family member to you?

- Spouse Parent Mother-in-Law Father-in-Law Child under 18 Child over 18

Other, please specify: _____

7. Is the family member's illness or disability verified by a doctor? YES NO

a. If yes, does the doctor state that care is needed by a family member at this time? YES NO

If yes, please provide a letter to the department from the ill/disabled family member's doctor which verifies that the family member is ill or disabled, the expected length of the illness/disability and that the individual requires care at this time which is best provided by a family member. Please fax to (401) 462-8318 within 72 hours.

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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8. Is the illness/disability short term or long term? SHORT TERM LONG TERM

9. Was there another family member who could have provided care for the ill/disabled family member? YES NO

a. If yes, why didn't this family member provide the care?

10. Was a leave of absence available to you? YES NO, a. If no, why wasn't a leave available?

b. If yes, a leave was available, did you ask for this leave of absence? YES NO, i. If no, why didn't you ask for a leave?

ii. If yes, you asked for a leave, did you take the leave of absence? YES NO

1. If no, why didn't you take the leave of absence?

2. If yes, you did take the leave of absence, then:

a. When did the leave of absence begin (mm/dd/yyyy): _____

b. When did it end or when is it scheduled to end(mm/dd/yyyy): _____

c. Was/is an extension of the leave of absence available? YES NO

i. If yes, did you request and take extension of the leave? YES NO

1. If no, why didn't you request or take the extension?

2. If yes, you requested and took the extension:

a. When did the extension begin(mm/dd/yyyy): _____

b. When did the extension end (mm/dd/yyyy): _____

11. Has the period of time for caring for the ill/disabled family member ended? YES NO

a. If yes, indicate the date that your care of the family member ended (mm/dd/yyyy): _____

12. Are you currently able to work full time? YES NO

13. Please provide any additional information you feel is necessary:

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

Signature: _____