STATE OF RHODE ISLAND
Rhode Island Department of Labor and Training
Income Support Division
1511 Pontiac Avenue
Cranston, RI 02920
Telephone: (401) 462-8418

Gina Raimondo
Governor
Scott Jensen
Director

WorkShare Agreement Between RI Department of Labor and Training and

The WorkShare program is in alternative for an employer to avoid layoffs when experiencing temporary major slowdown in business due to economic conditions.

The WorkShare plan submitted by the employer (see attached enclosures) certifies that the reduction in the usual weekly hours of work is in lieu of layoffs which would have affected at least 10 percent (10%) of the employees in the affected unit or units to which the plan applies and which would have resulted in an equivalent reduction in work hours.

The employer agrees to furnish required/requested reports relating to the proper conduct of the plan and agrees to allow the director or his or her authorized representatives access to all records necessary to verify the plan prior to approval and, after approval, to monitor and evaluate application of the plan.

Records of actual hours worked, including timesheets and/or time cards, must be maintained by the WorkShare employer for all individuals participating in the WorkShare program. This includes salaried employees who do not normally record hours of work.

Gross weekly wages of salaried employees must be reduced by the same percentage as the WorkShare hours of work.

The employer agrees that the number of hours worked indicated by the employer representative for each employee on each bi-weekly claim form is in fact, the number of hours actually worked by each employee during the indicated week/weeks.

A plan shall be effective on the date that is mutually agreed upon by the employer and the DLT Director which shall be specified in the notice of approval sent to the employer. It shall expire at the end of the twelfth (12^{th}) full calendar month after its effective date or on the date specified in the plan if that date is earlier; provided that the plan is not previously revoked by the Director. If a plan is revoked by the Director, it shall terminate on the date specified in the Director's written order of revocation.

In accordance with Rule 31, WorkShare Benefits Program, if an employer participates in the WorkShare Program for 18 months or more, within two consecutive years, the reduced hours shall become the standard for the usual weekly hours of work for the subsequent third year. The reduction will be computed based on the previous years' hours.

In addition, an employer will not be allowed to participate in the WorkShare Program for the same period of time each year for more than three (3) consecutive years as defined by "seasonal employment" in section 28-44-69(a)(6) of the Employment Security Act.

All affected units will be reduced by the maximum amount of hours before any layoffs are allowed, unless justification can be given as to why the layoff must occur in an affected unit.

Please submit your application via email to dlt.workshare@dlt.ri.gov

If dissatisfied with an initial determination, an employer may seek reconsideration by the Director, whose decision shall be final with no further appeal.

A WorkShare employer may not participate in the program during any week of a bona-fide vacation shut down or an economic shut down.

Please complete the Employer Representative section below, WHICH REQUIRES OFFICIAL NOTARIZATION, and return with your completed WorkShare packet information.

I certify that I have read and understand the above requirements for participation in the WorkShare program. I understand that violations of the terms of this contract will result in revocation of WorkShare approval and possible further penalty.

Printed Name of Authorized Employer Representative: _____

Signature of Authorized Employer Representative:_____

Date:_____

Do not complete this section. If your WorkShare plan is approved, you will receive this document complete with signature of an Authorized Representative of the Director of the RI Department of Labor and Training. A plan is not officially approved until this document is returned to your company with the section below complete.

Printed Name of the Authorized Representative of the Director of the RI Department of Labor and Training:

_____

Signature of the Authorized Representative of the Director of Labor and Training:

_____

Date:_____

WorkShare Plan Number:_____

Effective Date:_____

Please submit your application via email to dlt.workshare@dlt.ri.gov

STATE OF RHODE ISLAND

DEPARTMENT OF LABOR AND TRAINING

Workshare Unit

PO Box 20310, Cranston, RI 02920-0943
TTY Via RI Relay 711

OFFICIAL USE ONLY
Mailing Date:
Workshare Plan #:
Emp Reg No:
Unit Name:

1. Company Name: _____
2. Address of Worksharing: _____
3. Telephone: _____ Fax: _____ Email: _____
4. Specific type of business: _____
5. 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? _____%
6. On what date (**must be a Sunday**) do you want this plan to begin? _____
7. 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
8. Affected Unit: _____ Number of Employees: _____
   PLEASE LIST THE PARTICIPANTS FROM THE AFFECTED UNIT ON THE ATTACHED PARTICPANT LISTING
9. What percentage are the normal weekly hours of work reduced? _____%
10. Will fringe benefits be affected? ○ Yes ☐ No
    a. If yes, please specify which benefits and how they will be affected:
11. 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.

12. Are any employees who will participate in this plan covered by a collective bargaining agreement? ○ Yes ☐ No
13. 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: _____
14. 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: _____
15. 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.

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

OFFICIAL USE ONLY
Mailing Date:
Workshare Plan #:
Emp Reg No:
Unit Name:

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.		

Please submit your application via email to dlt.workshare@dlt.ri.gov