State of Oregon Employment Department

WORKSHARE

INITIAL CLAIM FORM

IMPORTANT: Please answer ALL questions completely. Failure to do so may result in denial of benefits.

- When a date is required, please provide the month, day and year in the following format: 01/01/2001
- To complete your initial claim, you must add your signature and the date of signing. Once complete, return this form to your employer as soon as possible.

Social Security Number:	Name: (Last, First, MI)		Phone:	
Applicant's Mailing Address: (Street or P.O.)	City:		State:	Zip Code:

Ethnicity: (Select all that apply)

☐ American Indian or Alaska Native ☐ Hawaiian Native or Other Pacific Islander
☐ Asian ☐ Asian & Pacific Islander
☐ Hispanic ☐ Other

Date of Birth:

☐ Male
☐ Female

Work Share Employer:			Phone:
Work Address: (Street or P.O.)			Employment Start Date:
City:	State:	Zip Code:	Job Title:

In the last 18 months:

A. Did you work for an agency of the Federal Government? ☐ Yes ☐ No
If yes, dates employed: _____ to _____

B. Have you served in the Armed Forces? ☐ Yes ☐ No
If yes, dates of service: _____ to _____

C. Did you work for an employer in another state? ☐ Yes ☐ No
If yes, please list the employer on the next page

D. Did you file a claim for benefits against any other state? ☐ Yes ☐ No
If yes, which state: _____

E. Did you work as a professional athlete? ☐ Yes ☐ No

F. **Are you a U.S. citizen?** ☐ Yes ☐ No
If no, can you legally work in this country? ☐ Yes ☐ No
If yes, please provide your work authorization number: _____

G. Are you receiving or will you receive retirement pay (other than Social Security) within the next 12 Months?
☐ Yes ☐ No

If yes, who is your retirement with:
_____

Amount per month:
$_____

When did you last work with this employer? _____

H. **Do you require information in a language other than English?** ☐ Yes ☐ No

If yes, what is your primary language: _____

For Office Use Only

Plan #: _____ Date Received: _____
Current Employer? ☐ Yes ☐ No Examiner: _____
Application: ☐ Approved ☐ Denied Date of Review: _____

If denied, reason for denial: _____

Please list all of your Employers for the past two (2) years. Include temporary or employee leasing agencies, employers in and outside the USA, the federal government and the military. To list more employers, use a separate piece of paper and attach it to this form. This information will be verified with your employer(s).

First Most Recent Employer: _____ Phone: _____

Address: (Street or P.O.) _____

_____

City: _____

State: _____ ZIP: _____

Job Title: _____

I worked for this employer from: _____ to _____

Check One:

☐ Still Working ☐ Leave of Absence

☐ Lack of Work ☐ Quit

☐ Strike/Lockout ☐ Fired/Suspended

Total (gross) earnings in above period of work: $_____

Rate of pay $_____

☐ HR ☐ Day ☐ WK ☐ MO ☐ YR

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You must report:

- Any work you missed or jobs you turned down
- Your job separations accurately, such as:
  - If you quit a job
  - If you were fired from your job
  - If you are on a leave of absence from your job
- If you were away from you permanent residence for more than three days during a week claimed.
- All work and gross earnings from any non-Work Share employer

Failing to provide this information may result in a denial of benefit and possible overpayment and penalties.

I certify under penalty of perjury that I am a citizen of the United States or legally authorized to work in the United States. I understand the questions I have been asked and my answers are true to the best of my knowledge. I understand the law provides penalties for making false statements in order to obtain unemployment insurance benefits. By submitting this application, I hereby request an initial determination of benefits potentially payable to me. I authorize the Employment Department to obtain and use information from any source I provide for administering unemployment insurance. Following this signed Initial Claim form, I understand and authorize my employer to submit Weekly Claim Certification forms on my behalf. I understand I am also responsible for communicating with my employer and the Oregon Employment Department of any changes to my status. I understand that failure to communicate status changes can result in a delay or denial of benefits. I further understand that any overpayment or misinformation is my responsibility. I understand that I can check the status of my claim by calling the Unemployment Insurance (UI) Special Programs Center at the number listed below.

☐ **By checking this box, I certify that I understand that it is my responsibility to know the information in both the Claimant and Work Share Handbooks.**
These handbooks can be found at www.OregonWorkShare.org
**By signing this form electronically, I understand that this electronic signature has the same meaning and validity as my handwritten signature.

Signature: _____ Date: _____

Oregon Employment Department • Attn: UI Special Programs Center• PO Box 14518 • Salem, Oregon • 97309
Phone: (503) 947-1800 • Fax: (503) 947-1833 • OED_workshare@oregon.gov

Disclaimer: If you send this form via email, it may not be secure. If you do not utilize email encryption software we advise you contact the UI Special Program Center at (503) 947-1800 or (800) 436-6191 to sign up with our secure email server. By clicking the submit button you acknowledge that you are responsible for ensuring the protection of the personally identifiable information included in this email.