EMPLOYER RESPONSE-QUIT:

NOTE: THIS INFORMATION WILL BE USED TO DETERMINE CLAIMANT'S ELIGIBILITY AND MAY ALSO AFFECT YOUR CHARGEABILITY RATE

Claimant Name:	SSN:
OROFINO LOCAL OFFICE IDAHO DEPT OF COMMERCE AND LABOR PO BOX 391 OROFINO ID 83544-0391 208-476-3471 (FAX)	Employer Name, Address, Phone & Fax

Paid or to be paid:

Gross earnings for the past 12 months $	Severance: $	On (date):
Vacation: $	Bonus: $	On (date):
Date vacation payment will be received:	Holiday: $	On (date):

Supervisor's name:	Employer's phone#:

Start date of employment:	Last day worked:	Date notice was given:

Please provide any documentation to support your position (ie: letter of resignation)

1. What reason (s) did the claimant give for quitting or giving notice to quit?

2 If the claimant cited work-related reasons, describe the working conditions:

3. What alternatives were available to the claimant? (Leave of absence, transfer, grievance, etc.)

4. Describe any efforts the claimant made to resolve the problem and the outcome of those efforts:

5. If you do not agree with the claimant's statements, please state why:

6. Additional information:

Employer/Employer's Representative Signature: _____

Print Name: _____ Title: _____

Phone Number: _____ Date: _____