



FLORIDA DEPARTMENT OF ECONOMIC OPPORTUNITY
 REEMPLOYMENT ASSISTANCE PROGRAM
 PO BOX 5250
 TALLAHASSEE, FL 32314-5250



16800810

HAYES, BRANDON
 205 SW 75TH ST APT 4U
 GAINESVILLE FL 32607

CLAIMANT ID: 2771483

CLAIM ID: 201301
 October 30, 2013

The following information is needed to determine your eligibility to receive reemployment benefits. You must respond to this information by 11/6/2013. You may also log into your account at <http://www.floridajobs.org/> to respond to this fact finding online.

Employment Information

Please note that information provided will be verified with the employer

| | |
|--------------------------------|-------------------------------------|
| Employer Name: | SHANDS TEACHING HOSPITAL AND CLINIC |
| Employer DBA: | SHANDS TEACHING HOSPITAL AND CLINIC |
| Employer Account Number (EAN): | 9950826 |
| Employment Start Date: | 08/20/2013 |
| Employment End Date: | 10/23/2013 |
| Work Schedule: | Full Time |

Section 1

Briefly describe your job duties



Date you were separated: / /

What are the details of the final incident that caused you to be separated?

Who initiated your separation? Name(s)/Title(s):

What was the reason for your separation?

When was the final event leading to your separation? / /

Section 2

We have identified the following issue Discharged - Health or Physical Condition as potentially impacting your eligibility for reemployment assistance. The information requested below is needed to determine your eligibility for benefits. Please answer all questions that apply to you.

Please select this checkbox and complete the items in this section if your issue type = **discharge** or **suspension**.

1.

A. Were you separated due to a discharge or suspension? Yes No

B. Were you warned prior to discharge? Yes No

C. If yes, provide the most recent warning was on what date? / /

D. In the box below, please provide the name, title and contact information of the person who fired or suspended you. Please attach a second page if additional space is required for your response.

E. In the box below, give the details of the final incident which caused your discharge / suspension:

2. Please select this checkbox and complete the items in this section if your issue type = **quit**.

A. In the box below, give the details of the final incident that caused you to quit your job. Please attach a second page if additional space is required for your response.

B. Did you quit for health reasons? Yes No

C. Did you quit do to a schedule change? Yes No

D Were the terms of hire changed or violated? Yes No

E. In the box below, please provide any additional details for questions B, C and D.

Please select this checkbox and complete the items in this section if your issue type = **suitable work**.

3.

A I was offered work / referred to a job on / / with the following employer.

Name

B.

Employer's Phone No.

C. Address

D I was was not referred to this job by the One Stop Career Center.

E. I was was not If offered the job, the offer was made by

(name and position/title).

F. Provide details of the job offered below such as type of work, starting pay and weekly work schedule.

G If you refused the referral or job offer, was it due to lack of transportation, housing or domestic responsibilities preventing you from accepting full time work?

Please select this checkbox and complete the items in this section if your issue type = **able & available** or **availability** or **ability** or **actively seeking**.

4.

A Did you make your recommended work search? Yes No

B. If no, please explain below.

C. Provide what dates you were not able and available to look for work, or work if work had been offered to you? From: / / To: / /

D If you did not seek work during this period, explain why and provide the dates you were not available to search for work.

E. Explain the efforts you made to remove the restriction affecting your availability for work.

5. Please select this checkbox and complete the items in this section if your issue type = **able & available WSI (work search indicator)**.

A Did you make your recommended work search? Yes No

Your availability for work is in question because you failed to provide information to show that you contacted at least five prospective employers in your search for work, or contacted your One-Stop Career center to receive reemployment services for the period shown below: From: / / To: / /

C. Did you submit 5 contacts for the period in question? Yes No

D Did you contact your local One-Stop center representative to discuss reemployment services? Yes No

E. Did you attempt to submit the One-Stop contact? Yes No

F. If yes, please list the 5 work search contacts below.

6. Please select this checkbox and complete the items in this section if your unemployment involves either **severance, vacation, wages in lieu of notice, worker's compensation, back pay award, VA**

Education Assistance Allowance, other (such as military) subsistence allowance, or war orphan's / widow's educational allowance.

At the time of separation, did you receive payment in the form of:

A. _____
(select one of the items listed above)?

B. The payment was based on (union contract, length of service, company policy, etc.).

C. You received vacation pay upon separation. Do you have a return to workdate? Yes No
If yes, please indicate the date: / /

D. Were you advised that 10/20/2013 would be your last physical day of work Yes No

E. Indicate all of the following types of income you are receiving that are based on your past work with a former employer. Enter gross amount per month. Pension
Other _____

F. Employer contributed 0% or 1-50% or 51-100% to my pension.

G. If a pension, enter the name and address of the employer from whom this pension was earned _____

H. Date you received first payment: Yes No

I. If you are receiving worker's compensation, is it total or partial worker's compensation _____

J. You became disabled on / /

K. The disability classification is (was):
 temporary total or permanent total or permanent impairment and wage loss benefits.

L. The name of the paying insurance carrier is _____

M. The phone number of the paying insurance carrier

N Please provide any additional details in the box below.

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7. If your issue is not one of the issues listed above, please select this checkbox and provide details in the box below.

Section 3

Please provide any information about this issue that you would like to add below:

Is there any additional documentation that you would like to send? Yes No

If yes, a cover sheet will be provided to you either by mail or online based upon your previously selected correspondence preference.

Please describe the documents:

Name of the person completing this request:

Telephone number of the person completing this request:

I certify the above information is true and correct.

Staff to Provide the Following Data (for office use only):

Contact the employer and document all information reported with the proper sources identified.

Employer's Name

Phone #

Person Contacted

Position

One Stop Career Center Representative's Name

Date / /
