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State of Illinois
Department of Employment Security
www.ides.illinois.gov

Report of Workers Affected by Labor Dispute Questionnaire

Employer Name: _____

Employer Account #: _____

In accordance with 56 Illinois Administrative Code 2720.130 (d)(3), when there is a work stoppage due to a labor dispute involving your company, you are required to supply the Illinois Department of Employment Security with a list of affected workers within five calendar days. If you have not done this yet please complete, sign and return this questionnaire to:

Illinois Department of Employment Security
Labor Dispute Section 9th Floor
33 South State Street
Chicago, IL 60603

If you need additional space, please use the other side of this document, if appropriate, or attach a separate sheet of paper.

Proper submission of the information requested on this form constitutes a sufficient protest as it relates to the labor dispute issue only. If you receive a Notice of Claim and believe that the claimant the notice refers to should be ineligible for benefits because of a reason other than the labor dispute, you must follow the instructions on the Notice of Claim to properly protest any other issue(s).

Section A: Labor Dispute Information

On what date did the following workers become unemployed? _____ / _____ / _____

List all Departments affected by the work stoppage.

List all work locations affected by the work stoppage.

Date of This Report: _____ / _____ / _____ Number of Pages Included: _____

Fax Number: _____

Section B: Signature

Signature: _____ Date: _____

Name (printed): _____ Telephone Number: _____

Title: _____ Ext.: _____

Section C: Worker Information

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER

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