



New York State Department of Labor
 Unemployment Insurance Division
 Liability and Determination Section
 State Office Building Campus
 Albany, NY 12240
 (518) 457-2635

Shared Work Program Application

Type or print in black ink.
 Complete all three pages.

The Department of Labor must have this application by the Monday before the plan start date. Return the completed form to the address above or fax to (518) 485-6172. Applications sent 4 weeks before the plan start date will not be considered.

Employer Information

1. Employer name _____

2. Employer Registration number

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3. Location code, if any

9	8	-					
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Plan Information

4. This is: A. New Plan B. Modification of an existing plan

5. **Plan start date:** On what date do you want this plan to become effective? _____

Note: Plan start date must be a Monday date.

Contact Information

6. Name of contact person

7. Title

8. E-mail ID

9a. Mailing address (number, street)

9b. City

9c. State, Zip

10. Business phone number
(include area code)

11. How many individuals do you employ full time in New York State? _____

12. Please estimate how many people would have been laid off without the Shared Work Program: _____

13. Are any employees who will take part in this program paid wages earned from piece work? Yes No
 If yes, give details about the piece work arrangements. Supply copies of any agreements or descriptions of how the employees are paid.

14. Collective Bargaining Agent(s) Concurrence

1. Union Name: _____	2. Union Name: _____
Local Number: _____	Local Number: _____
Name: _____	Name: _____
Title: _____	Title: _____
Street: _____	Street: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____
Telephone: () _____	Telephone: () _____
Signature: _____	Signature: _____

3. Union Name: _____	4. Union Name: _____
Local Number: _____	Local Number: _____
Name: _____	Name: _____
Title: _____	Title: _____
Street: _____	Street: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____
Telephone: _____	Telephone: _____
Signature: _____	Signature: _____

Employer Certification

I certify to the following:

- A. Without the Shared Work Program, I would be laying off workers. The reduced or restricted hours for all employees included in this Shared Work Program equals the hours that would be lost from the laid off workers.
- B. The employees' health insurance, medical insurance or any other fringe benefit will not be eliminated or diminished for the duration of the plan.
- C. Additional full-time or part-time employees will not be hired for the affected group for the duration of the plan.
- D. I understand the plan is to stabilize the work force during a period of temporary business decline. It will not be used to subsidize employers who have traditionally used part-time employees.
- E. Shared Work benefit payments may be charged to my unemployment insurance account (experience rated or reimbursable).
- F. The Commissioner will receive reports necessary for the proper administration of the plan upon request. The Commissioner can access all records necessary to verify the plan before approval and to evaluate its use.

Employer Name (Type or Print) _____ Title _____

Signature _____ Date _____

Signature must be of a corporate officer, sole proprietor or general partner.



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Shared Work Plan Participant Listing

If you have more than 20 people in an affected unit, photocopy this page for the additional names.
 If you have more than one affected unit, photocopy this page and complete it for each of the other units.

Employer Name and Work Site Address	Employer Registration Number	Date
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Affected Unit Name:

Proposed Percentage Reduction¹:

Employee First Name	MI	Employee Last Name	Employee Social Security Number	Normal Full-Time Hours ²	Union Name & Local Number ³	Piece Worker (Yes or No)	Effective Start Date on Shared Work ⁴
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

Number of full time employees in the affected unit: _____

Number of work sharing employees: _____

¹ Can be no less than 20% and no more than 60%.
² Must be at least 35 hours but not more than 40 hours per week.
³ If employee is a Union member, the respective collective bargaining agent must concur (item 14).
⁴ Required only for modifying an existing plan