UC-305 Rev. 2/16

CONNECTICUT DEPARTMENT OF LABOR - SHARED WORK
200 FOLLY BROOK BOULEVARD
WETHERSFIELD, CT 06109

Phone: (860) 263-6660 Fax: (860) 263-6681

Shared Work Plan Number _____

☐ New Request
☐ Modification Request

APPLICATION FOR SHARED WORK

Part A – SHARED WORK PLAN

1. Employer Name:	2. CTDOL Registration Number:
3. Mailing Address:	
4. Location of Company (if different than above):	
5. Contact Person:	6. Telephone Number:
5a. Email Address:	6a. Fax Number:
7. How did you become aware of the CT Shared Work Program?	

8. What are the affected units to which the Shared Work Plan applies? (An affected unit is defined as a specific department, shift, or other definable unit(s) consisting of not less than two employees to which an approved Shared Work plan may apply.)

Affected Unit	Bargaining Agent (if applicable)	Number of Employees in Unit	Number of Shared Work Employees

9. How many hours constitute your standard work week? _____

10. By what percentage(s) will the normal weekly hours of work be reduced? _____

11. Will all Shared Work employees in the affected unit be subject to the same percentage reduction in hours?
☐ Yes ☐ No

12. Will fringe benefits continue to be provided to employees in affected units as though their normal weekly hours have not been reduced? ☐ Yes ☐ No

13. Will service credits toward seniority accrue during the Shared Work plan at a rate at least commensurate with the amount of reduced hours actually worked? ☐ Yes ☐ No

14. Do you certify that you have paid all contributions for all past and current contribution periods as required under Connecticut General Statute Section 31-225a? ☐ Yes ☐ No

15. On what date (must be a Sunday) do you want this plan to begin? _____

15a. On what date (must be a Saturday, and no more than 26 weeks from the effective date) do you want this plan to end? _____

16. Do you observe a vacation shutdown during this period? ☐ Yes ☐ No

If yes, please give dates: _____

NOTE: *Planned vacation shutdowns are permissible under the Shared Work program; however, multiple temporary layoffs (furloughs) during an active plan are inconsistent with the program's objective, and therefore may represent good cause for the Connecticut Department of Labor to revoke an employer's plan.*

17. Do you certify that the implementation of a Shared Work plan and the corresponding reduction in work hours are in lieu of layoffs that would affect at least ten percent of all employees in the affected unit and would otherwise result in an equivalent reduction in hours? ☐ Yes ☐ No

If yes, approximately how many layoffs would be avoided by your company's participation in the Shared Work program? _____

18. Do you agree to apply this plan to only part time or full time permanent employees? ☐ Yes ☐ No

19. Are you a seasonal employer? ☐ Yes ☐ No (Seasonal means an employer who has a work base that is attached or dependent on a particular time of year on an annual basis).

IF YES, PLEASE NOTE: Shared Work is not intended to subsidize seasonal employers during **any off-season period.**

20. Do you agree to furnish all reports and information necessary for administration of the plan? ☐ Yes ☐ No

21. Do you agree to monitor and evaluate the operation of the established Shared Work plan as directed by the Connecticut Department of Labor? ☐ Yes ☐ No

22. Are any employees who will participate in this plan covered by a collective bargaining unit? ☐ Yes ☐ No

If yes, please identify the collective bargaining unit:

Union Name: _____ Union Name: _____

Address: _____ Address:_____

The applicable collective bargaining agent(s) must sign a collective bargaining concurrence statement provided below:

Collective Bargaining Agent(s) Concurrence:

I approve this Shared Work plan.

NAME: _____ NAME: _____

telephone: _____ telephone: _____

Signature: _____ Signature: _____

Title: _____ Title: _____

Date: _____ Date: _____

23. If your employees are not covered by a collective bargaining agreement, do you certify that a written copy of the proposed plan, or a summary thereof, has been made available to each employee in the affected group for inspection and comment for a period of at least seven (7) days? Please attach a copy of the proposed letter, with employee sign off, before your application can be approved. You must also attach copies of the proposed plan or summary and any comments made by employees with your application. ☐ Yes ☐ No

Employer Certification: I certify that the answers and information that I have provided for approval of this plan are complete, true, and correct. I have obtained a copy of Department of Labor Regulations Sections 31-250-8 through 31-250-12, inclusive, and agree to comply with the requirements set forth in those regulations.

THIS REPORT MUST BE SIGNED BY THE OWNER, A PARTNER, A CORPORATE OFFICER OR DULY AUTHORIZED EMPLOYER REPRESENTATIVE.

Name of Employing Unit (please print): _____ Date: _____

Signature: _____ Title: _____

The Connecticut Department of Labor will approve or deny this plan in writing within 30 days after its receipt. The determination is final and non-appealable. A denied plan does not prevent an employer from submitting another plan for approval. The Connecticut Department of Labor may revoke an approved Shared Work Plan for good cause.

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WETHERSFIELD, CT 06109

APPLICATION FOR SHARED WORK (Note: Please Print)

Part B – SHARED WORK PLAN PARTICIPATION LIST

Employer Name: _____

Percentage(s) reduction in normal weekly hours of work: _____

Affected unit designation: _____

Please use separate list for each affected unit

NAME OF AFFECTED EMPLOYEE	SOCIAL SECURITY NUMBER	IF PART TIME, STANDARD HOURS:	IF FULL TIME, STANDARD HOURS:
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NAME OF AFFECTED EMPLOYEE	SOCIAL SECURITY NUMBER	IF PART TIME, STANDARD HOURS:	IF FULL TIME, STANDARD HOURS:
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NAME OF AFFECTED EMPLOYEE	SOCIAL SECURITY NUMBER	IF PART TIME, STANDARD HOURS:	IF FULL TIME, STANDARD HOURS:
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NAME OF AFFECTED EMPLOYEE	SOCIAL SECURITY NUMBER	IF PART TIME, STANDARD HOURS:	IF FULL TIME, STANDARD HOURS:
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NAME OF AFFECTED EMPLOYEE	SOCIAL SECURITY NUMBER	IF PART TIME, STANDARD HOURS:	IF FULL TIME, STANDARD HOURS:
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NAME OF AFFECTED EMPLOYEE	SOCIAL SECURITY NUMBER	IF PART TIME, STANDARD HOURS:	IF FULL TIME, STANDARD HOURS:
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NAME OF AFFECTED EMPLOYEE	SOCIAL SECURITY NUMBER	IF PART TIME, STANDARD HOURS:	IF FULL TIME, STANDARD HOURS:
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NAME OF AFFECTED EMPLOYEE	SOCIAL SECURITY NUMBER	IF PART TIME, STANDARD HOURS:	IF FULL TIME, STANDARD HOURS: