



SHARED WORK PROGRAM **PLAN EXTENSION REQUEST**

Email: DOL.SharedWork@ct.gov

Fax: 860-263-6681

Or Mail: Connecticut Department of Labor
ATTN: Shared Work Program
200 Folly Brook Boulevard
Wethersfield, CT 06109

Our records indicate your current Shared Work Program Plan # _____ will expire as of Saturday, _____

In order to extend your company's participation in the Shared Work Program, the following terms must be agreed to:

_____ Agrees to continue conforming to Regulations Sections 31-250-8 through 31-250-12, Inclusive, governing the original Shared Work Program Plan. Requests for any change(s) in this plan must be made to the Shared Work Program Coordinator prior to implementation of such requested change(s).

Please complete the following:

The requested **EFFECTIVE** date is: Sunday, _____

An extension of _____ weeks (26 maximum) is requested.

Do you plan to observe a vacation shutdown during the period: ☐ Yes ☐ No

If yes, provide shutdown dates: _____

***Please call the Shared Work Unit at (860) 263-6660 for additional instructions.**

This request must be signed by an owner, a partner, a corporate officer or duly authorized employer representative.

(Signature of company official)

(Date)

(Printed name and title of above signatory)

(Telephone number)