



**Department of Labor**

Unemployment Insurance Division  
Liability and Determination Section  
Harriman State Office 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 three weeks prior to 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 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: _____

If you have additional Collective Bargaining Agent(s), provide information on a separate sheet and attach it to this application.

**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, retirement or any other fringe benefit in effect prior to the Shared Work application will not be eliminated or diminished unless such benefits are eliminated or diminished for the entire work force.
- C. Additional employees will not be hired for the affected group for the duration of the plan.
- D. I have provided notification of the proposed Shared Work Plan to my workforce.
- 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.
- G. The union(s) representing the employees identified as participants have reviewed and provided written consent to the plan which will be retained and produced upon request.

Employer Name (Type or Print) \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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