pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
OFFICE OF UNEMPLOYMENT COMPENSATION BENEFITS POLICY

SHARED-WORK PLAN
EMPLOYER APPLICATION

PART A: EMPLOYER INFORMATION

Employer Name:	Employer Account Number:	
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
Contact Person:	Email:	

PART B: WRITTEN PLAN

A written Shared-Work plan is required. Please complete the following:

Describe the manner in which your company intends to implement the Shared-Work plan, if approved. Please include in your statement any changes/additions that you plan to make to health care benefits, training provided to the employees or changes to other employee benefits.
Provide an estimate of the number of layoffs that will occur if you do not participate in the Shared-Work program.
How and when will you inform the affected workers about the reduction in hours, if your plan is approved?
What is your expectation for the end of the Shared-Work period? (For example: return to full work, company changing hands, company reorganization, etc.)

What product does your company produce and/or what type of service do you provide?
How or where did your learn about the Shared-Work program (optional)?
Other comments

PART C: PLAN INFORMATION

Affected Unit Name:	First date that hours will be reduced:
No. of weeks the plan will be in effect: _____ (maximum 52 consecutive weeks)[1]	Reduction Percentage: _____ percent (minimum 20 percent–maximum 40 percent)
Are any participating employees covered by a collective bargaining agreement (CBA)? ☐ YES ☐ NO If yes, Part D of this application must be executed by the authorized collective bargaining representative(s).	

[1] The effective period of a Shared–Work plan combined with effective periods of the participating employer's past Shared–Work plan(s) may not equal more than 104 weeks out of a 156–week period.

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Will there be any weeks during the effective period of the plan when participating employees' hours will be reduced by more than the reduction percentage due to holidays, designated vacation periods, equipment maintenance or other similar circumstances?

☐ YES ☐ NO

If yes, indicate all dates that apply.

PART D: EMPLOYEES

Participating employees in the affected unit (minimum of 2, determined without regard to participating employees who are corporate officers).

Social Security No.	Name	Normal Work Hours	Work Hours Under Shared-Work plan

I certify that:

☐ All participating employees have been employed in the affected unit for at least 3 months prior to the application date of the Shared-Work plan.

☐ None of the participating employees will work 40 or more hours per week after his or her hours are reduced by the reduction percentage.

☐ None of the participating employees in the affected unit are employed on a seasonal, temporary or intermittent basis.

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PART E: COLLECTIVE BARGAINING REPRESENTATIVE(S) CONSENT:

The authorized collective bargaining representatives certify that they approve the Shared–Work plan set forth in this application.

Union Name:_____	Union Name:_____
Union Local Number:_____	Union Local Number:_____
Telephone Number: _____	Telephone Number: _____
_____ Name of Authorized Union Representative	_____ Name of Authorized Union Representative
_____ Position Title	_____ Position Title
_____ Authorized Union Representative Signature	_____ Authorized Union Representative Signature
Date: _____/ _____/ _____	Date: _____/ _____/ _____

Union Name:_____	Union Name:_____
Union Local Number:_____	Union Local Number:_____
Telephone Number: _____	Telephone Number: _____
_____ Name of Authorized Union Representative	_____ Name of Authorized Union Representative
_____ Position Title	_____ Position Title
_____ Authorized Union Representative Signature	_____ Authorized Union Representative Signature
Date: _____/ _____/ _____	Date: _____/ _____/ _____

PART F: ASSURANCES AND CERTIFICATIONS

The employer makes the following assurances and certifications, all of which are material elements of this application:

1. The employer's certification that the implementation of a Shared-Work plan is in lieu of layoffs that would affect at least 10% of the employees and would result in an equivalent reduction in work hours.

2. The employer's assurance that it will not hire new employees in or transfer employees to the affected unit during the effective period of the Shared-Work plan.

3. The employer's assurance that it will not lay off participating employees during the effective period of the Shared-Work plan.

4. If the employer provides health and retirement benefits under a defined benefit plan or contributions under a defined contribution plan, to an employee in a plan, the employer must certify that these benefits will continue under the same terms and conditions as though the hours of work had not been reduced or to the same extent as other employees not participating in the plan.

5. The employer's assurance that it will abide by all terms and conditions of the Shared-Work requirements in the PA UC Law.

6. An assurance that it will provide reports to the department relating to the operation of its Shared-Work plan as requested.

7. The employer's attestation that its implementation of the Shared-Work plan is consistent with the employer's obligations under federal and state law.

Please sign and return your completed application to the Office of UC Benefits Policy, ATTN: Shared–Work, 651 Boas St., Room 610, Harrisburg, PA 17121, or by fax 717-772-0344. If you have any questions regarding the application process contact SharedWork@pa.gov.

Please be advised that the department cannot guarantee the security of personally identifiable information submitted via unsecured means such as: fax or unencrypted email systems.

I certify that all information I have provided in this document is correct and complete. I acknowledge that false statements in this document are punishable pursuant to 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

_____ _____

Employer Signature Date

_____

Title

A person who knowingly makes a false statement or knowingly withholds information to obtain UC benefits commits a criminal offense under section 801 of the UC law, 43 P.S. §871, and may be subject to a fine, imprisonment restitution and loss of future benefits.

FOR DEPARTMENT USE ONLY

DEPARTMENT SIGNATURE :	
DATE:	TITLE:
PLAN NUMBER:	

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program