DIVISION OF EMPLOYMENT SECURITY

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

SHARED WORK PLAN APPLICATION

573-751-WORK
www.SharedWork.mo.gov

AGENCY USE ONLY PLAN NO.

A. EMPLOYER INFORMATION

1. Employer Name		2. Missouri Employer Account No.
3. Missouri Location Address		4. Telephone No. (Include Area Code)
3a. Complete Mailing Address		
5. Affected Unit	6. Number of Workers	7. Number of Affected Workers
8. Estimate the number of employees that would be laid off if there were no participation in the Shared Work Program		
9. Do you certify the Shared Work Plan describes the manner in which employees in the affected unit will be notified and that advanced notice will be given? ☐ Yes ☐ No If No, explain why it was not feasible to provide advanced notice:		

B. EMPLOYER CERTIFICATION

I certify that fringe benefits shall continue to be provided to participating employees under the same terms and conditions as though the employee's normal hours had not been reduced or to the same extent as other employees not participating in the Shared Work Program. I certify that participation in the Shared Work Program and its implementation is consistent with my obligation under applicable federal and state laws. I understand that the Shared Work Program will not be denied to employees in training that is approved by the director, such as employer-sponsored training or training funded under the Workforce Investment Act of 1998. I understand that I must file a certification of hours worked at least every two weeks for those employees whose hours have been reduced under the Plan. I certify our plan will reduce hours by 20 to 40 percent. I certify that the implementation of this Shared Work Plan, and the resulting reduction in work hours, is in lieu of layoffs that would apply to at least 10 percent of the affected unit.

Employer or Representative	Title
Signature	Date

C. COLLECTIVE BARGAINING INFORMATION

(Complete only if the affected workers are members of a union.)

Union Name	Local No.	Union Official	
Title of Official	Signature		Date

FOR AGENCY USE ONLY - DO NOT COMPLETE BELOW THIS LINE

Employer Current: ☐ Yes ☐ No Initials _____ Date _____

Determinations: ☐ Denied ☐ Approved Beginning _____ *(Mo., Day, Yr.)* Ending _____ *(Mo., Day, Yr.)*

Reason for denial: _____

_____ *(Director)* _____ *(Date)*

***IMPORTANT**: If needed, call 573-751-6548 for assistance in the translation and understanding of the information in this document.*
***¡IMPORTANTE!**: Si es necesario, llame al 573-751-6548 para asistencia en la traducción y entendimiento de la información en este documento.*