District of Columbia
Application for Shared Work

VINCENT C. GRAY
MAYOR

LISA MARIA MALLORY
DIRECTOR

PLEASE EMAIL YOUR COMPLETED APPLICATION TO sharedwork@dc.gov.

Part A – SHARED WORK PLAN			☐ **New Request** ☐ **Modification Request**
		Application Date	
DOES Account Number			
FEIN:		**Ward Number:**	
		Use this link to find your ward number →	http://www.neighborhoodinfodc.org/pdfs/ward_zip.pdf

1. **Employer Information**

Employer Name:					
Principal Business or Industry:					
Mailing Address:					
	Street or Post Office Box	**Suite No**	**City**	**State**	**Zip Code**
Location of Shared Work, if Different					
	Street or Post Office Box	**Suite No**	**City**	**State**	**Zip Code**

2. Does your business operate as non-profit, government, or public entity? ☐ Yes ☐ No
   If yes, please select the type of public entity that best describes your organization.

☐ DC Government	☐ School District	☐ Federal	☐ Higher Education	☐ Other (Specify)

3. **Employer Representative:** An employer representative must be provided to coordinate with Shared Work Program staff in all matters pertaining to the employer plan and eligible employee claims.

Primary Employer Representative				**Alternate Employer Representative**			
Name:				Name:			
Job title:				Job title:			
Email:				Email:			
Phone:		Ext.		Phone:		Ext.	
Fax:				Fax:			

4. List the "affected units" to which the Shared Work Plan applies. An affected unit is defined as a specific department, shift, or other definable unit consisting of not less than two (2) employees to which an approved Shared Work Plan applies. Furthermore, the Shared Work Plan must not reduce the normal weekly hours of work for an employee in the affected unit by less than 20% and not more than 40%. Attach an additional page if necessary.

Affected Unit	**Bargaining Agent (if applicable)**	**Location Street Address Washington, DC Example: 4058 Minnesota Ave NE**	**Number of Employees in Unit**	**Number of Shared Work Employees**	**Number of Hours in Standard Work Week**	**Percentage of Normal Weekly Work Hours Reduced**
						%
						%
						%
						%
						%

5. Will all Shared Work employees in the affected unit(s) be subject to the same percentage of reduction in hours? ☐ Yes ☐ No

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

7. 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

8. When do you anticipate reducing or when did you reduce work hours?

9. On what date do you want this Shared Work Plan to become effective? (must be a Sunday)

10. On what date do you want this Shared Work Plan to end? (must be a Saturday)

11. Will you have any planned vacations or closures during this period? ☐ Yes ☐ No If yes, list the date(s) below: MM/DD/YYYY

NOTE: Planned vacations or closures 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 District of Columbia Department of Employment Services (DOES) to terminate an employer's Shared Work Plan.

12. Do you certify that the implementation of the Shared Work Plan and the resulting reduction in work hours are in lieu of temporary layoffs that would affect at least 10% of all employees in the affected unit(s) and would otherwise result in an equivalent reduction in hours? ☐ Yes ☐ No

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

13. Do you agree to apply this Shared Work Plan to only permanent, full-time employees? ☐ Yes ☐ No

14. Do you agree to continue to maintain health benefits as though weekly work hours are not reduced? ☐ Yes ☐ No

15. 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).

    NOTE: Shared Work is not intended to subsidize seasonal employers during any off-season period or to subsidize employers who have traditionally used part-time employees.

16. Do you agree to furnish all reports and information necessary for administration of the Shared Work Plan? ☐ Yes ☐ No

17. Do you agree to monitor and evaluate the operation of the established Shared Work Plan as directed by DOES? ☐ Yes ☐ No

18. Do you certify that you have paid all contributions for all past and current periods as required for an employer operating in the District of Columbia and subject to the District of Columbia Unemployment Compensation Act? ☐ Yes ☐ No

19. Are any employees who will participate in this Shared Work Plan covered by a collective bargaining agreement? ☐ Yes ☐ No
    If yes, please complete the following section:

Union Name:		Local		Union Name:		Local	
Address Line 1:				Address Line 1:			
Address Line 2:				Address Line 2:			
City:				City:			
State :		Zip Code:		State:		Zip Code:	
Phone Number		Fax Number:		Phone Number		Fax Number:	

The applicable, authorized union representative must approve the Shared Work Plan and must sign the concurrence statement provided below in order for your application to be considered for review.

CONCURRENCE STATEMENT

By signing below, I certify that I am the authorized union representative and that I have reviewed and concur with the proposed Shared Work Plan.

Authorized Union Representative		**Authorized Union Representative**	
Name:		Name:	
Title:		Title:	
Phone		Phone:	
Email:		Email:	
Signature:		Signature:	

20. If your employees are not covered by a collective bargaining agreement, do you certify that a written copy of the proposed Shared Work Plan, or a summary thereof, was made available to each employee in the affected group for inspection and comment for a minimum of seven (7) days? ☐ Yes ☐ No Please attach copies of the summary made available to the affected group and any employee comments to your application.

CERTIFYING INFORMATION

1. As an experience rated employer using the tax rate method, I understand that my reserve account will be charged 100% for benefits paid under this Shared Work Plan. In addition, I understand that these charges may increase my unemployment insurance contribution tax rate in future years.

2. As a reimbursable employer, I understand that I will be charged 100% for benefits paid under this Shared Work Plan. I understand that I will be billed quarterly for the cost of benefits paid under this Shared Work Plan in the same manner as I am currently billed for other unemployment insurance benefits.

3. I understand that a holiday cannot be used as a Shared Work day unless the employee(s) in the same position performed compensated services, as part of the employee(s) normal weekly hours of work on that holiday, during the 12-month period prior to the employer's participation in the Shared Work Program. Furthermore, I understand that I am not to certify a holiday as the only Shared Work day during a calendar week.

4. I will provide DOES with the weekly percent of reduction in hours and wages for each participating employee as a result of this Shared Work Program.

5. I understand that in order to be eligible, any employee must have worked at least one normal work week with no reductions prior to the issuance or enrollment in the Shared Work Program.

6. I understand that if any employee is working for a school district and/or non-profit entity providing services to a school district, I must provide DOES with the dates individual employees are between successive academic terms and/or in a recess period. Furthermore, I understand that I am not to submit certifications to DOES for employees for those weeks the employee is between successive terms or in a recess period, where there is a reasonable assurance that the employee will return to work.

7. I understand that a Shared Work Plan approved by DOES shall expire 12 months after its effective date. Any approved modification shall expire on the same date as the original Shared Work Plan. A new Shared Work Plan may be approved immediately following the expiration of the previous Shared Work Plan, if the employer applies for approval of the new Shared Work Plan prior to the expiration of the previous Shared Work Plan and the employer finds it necessary to provide employees with continuous coverage under this Shared Work Program.

8. I have provided the information on this form so that our employees may participate in the Shared Work Program, in lieu of layoffs. I understand that failure to provide correct information, in accordance with this certification and in accordance with the provisions of the District of Columbia Unemployment Compensation Act, could result in a denial or termination of this plan.

9. I have obtained a copy of the DOES Shared Work Plan requirements and agree to comply with those requirements. If approved for the Shared Work Program, I agree to file the Shared Work Certifications with DOES on behalf of my affected employees in an electronic format prescribed by DOES.

FOR PRIVATE SECTOR EMPLOYERS: THIS APPLICATION MUST BE SIGNED BY THE OWNER, A PARTNER, A CORPORATE OFFICER, OR DULY AUTHORIZED EMPLOYER REPRESENTATIVE, SUBSTANTIATED IN WRITING TO EXECUTE THE SHARED WORK PLAN.

FOR PUBLIC SECTOR EMPLOYERS: THIS APPLICATION MUST BE SIGNED BY THE EXECUTIVE DIRECTOR, OR A PERSON WITH AUTHORIZATION, SUBSTANTIATED IN WRITING TO EXECUTE THE SHARED WORK PLAN.

BY SUBMITTING THIS FORM, I CERTIFY THAT I HAVE READ AND AGREE TO THE OFFICIAL RULES, TERMS, AND REQUIREMENTS OF THE DOES SHARED WORK PROGRAM. I ALSO CERTIFY THAT I AM THE AUTHORIZED EMPLOYER REPRESENTATIVE, AND ALL INFORMATION PROVIDED IN THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I ALSO UNDERSTAND THAT THIS INFORMATION IS SUBJECT TO VERIFICATION, AND I FURTHER UNDERSTAND THAT PROVIDING ANY FALSE OR INACCURATE INFORMATION MAY RESULT IN DENIAL OF THE APPLICATION FOR, OR TERMINATION FROM, THE SHARED WORK PROGRAM AND MAY SUBJECT ME TO CIVIL AND/OR CRIMINAL PROSECUTION AND PENALTIES.

Name and Title of Authorized Employer Representative: ______________________________ **Date:** ______________

Signature: ______________________________