SHARED WORK WEEKLY CERTIFICATION REPORT

Employer Name:
Shared Work Plan No.

Week Ending Date (mm/dd/yy): (week begins on Sunday, ends on Saturday)

Shared Work Employer: Please list below all employees named on your original Shared Work Plan. Indicate the percentage of reduced hours for each employee. ****Please note: This list must represent all of the employees indicated on your Shared Work Plan.**

I certify that the information provided on this form is true and correct.

Signature:
Title:
Telephone No.:
Date (mm/dd/yy):

Employee Name	Social Security No.	Percentage of Reduction

Print Reset Form*

***resetting this form will delete all employee information**

PLEASE NOTE: If you have more employees to list, please us the Continuation Sheet, located at: **http://www.ctdol.state.ct.us/progsupt/bussrvce/shared_work/CertCont.pdf**