IOWA WORKFORCE DEVELOPMENT
vswclaims@iwd.iowa.gov

70-5033 (07/19)

VOLUNTARY SHARED WORK (VSW) PLAN APPLICATION

EMPLOYER INFORMATION

NOTE: A separate application needs to be submitted for each work unit.

1. EMPLOYER NAME		2. EMPLOYER ACCOUNT NUMBER	
3. ADDRESS (STREET OR P.O. BOX)	CITY	STATE	ZIP
4. EMAIL ADDRESS		5. PHONE NUMBER	
If the business location, the name or subsidiary where the work sharing will occur is different than above, please complete items 6-8.		6. EMPLOYER NAME	
7. ADDRESS (STREET OR P.O. BOX)	CITY	STATE	ZIP
8. PHONE NUMBER	9. EMPLOYER CONTACT NAME	10. TOTAL NUMBER OF WORKERS AFFECTED	
11. HOW DID YOU HEAR ABOUT THE VSW PROGRAM?	12. WILL THE REDUCTION IN WORK HOURS AFFECT PARTICIPATING EMPLOYEES' FRINGE BENEFITS (I.E. HEALTH, 401K, ETC.)? YES _____ NO _____		
13a. Hours for full-time employee: NORMAL HOURS BEFORE VSW_____ EXPECTED HOURS WITH PLAN _____	13b.. Hours for part-time employee: NORMAL HOURS BEFORE VSW_____ EXPECTED HOURS WITH PLAN _____		
14. EXPECTED START DATE FOR REDUCED WORK	15. EXPECTED DURATION OF VSW WEEKS: _____ END DATE: _____		
16. ESTIMATED NUMBER OF LAYOFFS TO OCCUR WITH NO VSW PROGRAM	17. TOTAL NUMBER OF EMPLOYEES AFFECTED FOR THE WORK UNIT		
18. ARE ANY EMPLOYEES WHO WILL PARTICIPATE IN THIS VSW PLAN COVERED BY A COLLECTIVE BARGAINING AGREEMENT? YES _____ NO _____If yes, the collective bargaining agent must complete and sign the collective bargaining section below.			
19. REASON FOR THE REDUCTION IN HOURS *Note: Voluntary Shared Work is not to be used as a supplement during normal or seasonal layoffs.*			

Please fill in the table of information below with the requested data for all affected full-time and part-time employees (seasonal employees not included). If identifying more than one work unit, submit another application.

20. NAME OF WORK UNIT	NUMBER OF EMPLOYEES	NUMBER OF EMPLOYEES REDUCED	PERCENT OF EMPLOYEES REDUCED	HOURS REDUCED (20% minimum – 50 maximum)	
				ORIGINAL %	REDUCED %

COLLECTIVE BARGAINING INFORMATION (if applicable)

21. UNION NAME	22. LOCAL NUMBER	23. UNION OFFICIAL
24. TITLE OF OFFICIAL	25. SIGNATURE	26. DATE (MM/DD/YYYY)

I (Employer Representative) certify that the following Iowa Workforce Development rules and regulations according to Iowa Code 96.40 and Iowa Administrative Rule 871 – 24.58(96) have been met and will be followed while the VSW plan is in effect:

1. All employer reports have been filed for the past and current period and all contributions (taxes) have been paid in full.
2. The aggregate reduction in work hours is in lieu of layoffs which would have affected at least ten percent of the employees in the affected unit which would have resulted in an equivalent reduction in work hours.
3. All employees in the affected unit will be identified by name and social security number and consist of at least five individuals.
4. The shared work plan reduces the normal weekly hours of work for an employee in the affected unit by not less than twenty percent and not more than fifty percent with a corresponding reduction in wages.
5. The reduction in work hours for employees is not based on a work week exceeding forty hours.
6. The plan will automatically be revoked if an employer lays off any employee, where the employee is employed within an affected unit or not, while participating in the shared work unemployment compensation program.
7. The reduction in hours and corresponding reduction in wages MUST be applied equally to all employees in the affected unit.
8. The plan provides that fringe benefits will continue to be provided to employees in affected units.
9. The plan WILL NOT serve as a subsidy of seasonal employment during the off season, nor as a subsidy of temporary part-time or intermittent employment.
10. The employer will not hire additional part-time or full-time employees for the affected work force while the plan is in operation.
11. The duration of the plan will not exceed 52 weeks.
12. The plan is approved in writing by the collective bargaining representative for each employee organization or union which has members in the affected unit.
13. The plan requires advanced notice to all employees in the affected unit.

Please describe below how the employees in the affected unit will be notified about participation in the Voluntary Shared Work Plan.

27.

28. EMPLOYER REPRESENTATIVE NAME (PRINT)	29. TITLE
30. SIGNATURE	31. DATE (MM/DD/YYYY)

EMPLOYER REPRESENTATIVE CERTIFICATION

Please return the completed VSW application to vswclaims@iwd.iowa.gov.

Note: All employees are required to review and complete the Employee Data Collection Form prior to the plan being approved. Iowa Workforce Development may revoke approval of a shared work plan and terminate the plan if the department determines that the shared work plan is not being executed according to the terms and intent of the shared work unemployment compensation program.