UC-307 (Rev. 12/14)

SHARED WORK

AMENDED/CORRECTED CERTIFICATION REPORT

Connecticut Department of Labor
200 Folly Brook Boulevard
Wethersfield, CT 06109

Employer Name: _____

Shared Work Plan No. _____

Week Ending: _____

Provide the original information submitted and the required change for the affected employee(s) **only.**

Example:

Employee Name	Social Security No.	Original Submission	Change Required
John Smith	123-45-6789	Do Not Pay	Pay at 20 Percent

Employee Name	Social Security No.	Original Submission	Change Required
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

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

Signature: _____ Title: _____

Telephone No.: _____ Date: _____

Please fax this information to: Attn: Shared Work Program – Fax: 860-263-6681