Employment Security Department
WASHINGTON STATE

SharedWork
WEEKLY CLAIM CORRECTION FORM

Submit by fax to 800-301-1796
Questions? Call 800-752-2500, option 4

Use this form to make corrections to the employee's weekly claim(s). **One form per person.**

When an employee participating in SharedWork certifies for benefits, we pay based on that certification. The employer representative is responsible for verifying the information contained on the SharedWork Payment Report and reporting any differences in writing within 10 working days. (See WAC 192-250-025 (6))

Compare your SharedWork Payment Report to your payroll records and report *any discrepancy* in hours and/or gross earnings. Provide the corrected hours and gross earnings in sections 2 and 3 below. Include any leave without pay* information in section 4. ***Incomplete forms will not be processed.***

Employer name:	Employee name:
ESD number: (Found on your ESD tax statements)	Social Security number:

1			2								3		4							
Week Ending (SATURDAY date)	Employee Reported		Worked		Sick Pay		Holiday Pay		Vacation Pay		Weekly Total		Leave Without Pay* Mark (x) the day(s) and reason(s) unpaid leave was taken.							
	Hours	Earnings	Hours	Gross Earnings	Hours	Gross Earnings	Hours	Gross Earnings	Hours	Gross Earnings	Hours	Gross Earnings	S	M	T	W	T	F	S	Reason
1. (MM/DD/YY)																				
2.																				
3.																				
4.																				

*If additional work was offered to the employee but they declined it, was the work offered with at least 24 hours' notice? ○ Yes ○ No

SHAREDWORK PARTICIPATING EMPLOYEE: You may have been overpaid for the week identified above if you reported hours worked and earnings that were less than what your employer reported, or if you were not available for all work offered. **Please choose one.**

○ I agree with the information my employer reported. I understand if I was overpaid then I am liable for repayment.
○ I do not agree with the information my employer reported. I am requesting an interview.

Employee signature: _____ Date: _____ MM/DD/YYYY

☐ Employee refused to sign. ☐ Employee separated on _____ MM/DD/YYYY due to **(select one)** quit / fired / permanent layoff.

EMPLOYER REPRESENTATIVE: The information I have provided is true to the best of my knowledge.

Signature: _____ Date: _____ MM/DD/YYYY

Title: _____ Phone: _____

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