North Carolina Department of Commerce
Division of Employment Security
Unemployment Insurance

Request for Separation and Wage Information
Trade Act of 1974, Amended 2002

Employer Worker's Name (Last, First, MI)

/ /

Social Security Number

Petition Number

Notice to Employer: The worker identified above has filed a request for a Determination of Entitlement to Trade Readjustment Allowances under the Trade Act of 1974, Amended 2002. If the worker was partially separated prior to being totally separated, please complete both the Partial and Total Separation sections below (the qualifying period for the Partial and Total separations differ). Please return the completed form to the address shown below within 15 days.

Partial Separation: The qualifying period for the **partial separation** begins on _____ and ends on _____.

___/___/___ Enter the last day worked prior to partial separation.

(Month) (Day) (Year)

Reason separated: ☐ **Lack of Work** ☐ **Other** If "other," explain:

_____ Enter the number of weeks worked during the qualifying period in which earnings were $30 or more. **(if the number of weeks is less than 26, complete the items below.)**

_____ Enter the number of weeks of authorized leave (leave taken for vacation, sick, injury, maternity, inactive or active duty military service, time to serve as a full time labor organization representative.

_____ Enter the number of weeks of disability (leave compensable under Worker's Compensation Law).

Total Separation: The qualifying period for the **total separation** begins on _____ and ends on _____

___/___/___ Enter the FIRST day worked and

___/___/___ Enter the LAST day worked prior to total separation.

(Month) (Day) (Year)

Reason separated: ☐ **Lack of Work** ☐ **Other** If "other," explain:

_____ Enter the number of weeks worked during the qualifying period in which earnings were $30 or more. **(If the number of weeks is less than 26, complete the items below.)**

_____ Enter the number of weeks of authorized leave (leave taken for vacation, sick, injury, maternity, inactive or active duty military service, time to serve as a full time labor organization representative.

_____ Enter the number of weeks of disability (leave compensable under Worker's Compensation Law).

Employer _____ Title _____

Date Completed _____ Telephone Number _____

Please upload completed form to your Employer Portal at des.nc.gov
Or

Mail or Fax completed form to: Post Office Box
Raleigh, NC 27611-5903
Fax Number 919.715.7642

Help us prevent UI Fraud
by responding accurately and timely
to requests for information

NC CLM 8-55A