

DISTRICT COUNCIL #4  
HEALTH & WELFARE FUND  
585 Aero Drive  
Cheektowaga, NY 14225  
Phone – (716) 565-0234  
Fax – (716) 565-1494

VACATION FORM



NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE#: \_\_\_\_\_ Last 4 of SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_

TF Initial \_\_\_\_\_  
Trustee Override \_\_\_\_\_

VACATION PERIOD:

(BENEFIT IS SIX WEEKS VACATION BETWEEN JUNE 1st AND MAY 31<sup>st</sup>)

BEGINNING DATE: _____	ENDING DATE: _____	
NUMBER OF WEEKS: _____		Required in Account
\$1421.59/WK. (JOURNEYMAN) _____		\$1600.00
\$755.22/WK. (APPRENTICE) _____		\$850.00
\$755.22/Wk. (INDUSTRIAL) _____		\$850.00

\*\*\*Please be sure to check the appropriate line, by signing this form you are taking responsibility for your choice!\*\*\*

I HEREBY CERTIFY THAT I WILL BE ON VACATION AND  
REQUEST \_\_\_\_\_ WEEK(S) OF VACATION.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**IF YOU ARE COLLECTING UNEMPLOYMENT YOU MUST NOT BE COLLECTING VACATION PAY UNLESS YOU ARE CLAIMING IT TO THE DEPARTMENT OF LABOR PER NYS DOL!!!!**