

FMCS 8(g) Notification of Intention to Strike or Picket at Any Health Care Institution

Instructions for completing this form:

FMCS accepts the “FMCS 8(g) Notice” as required by Section 8(g) of the National Labor Relations Act, 29 U.S.C. § 158.

When submitted, this Online form provides you with a confirmation number and submission date for proof of submission and future reference. Please retain your confirmation number to reference in future communication with FMCS personnel.

NOTE:

1. The 8(g) Notice and confirmation number that you receive will be sent to the official filer via email.
2. FMCS is not responsible for inaccurate information entered into this form. Typographic errors may cause processing delays.
3. FMCS does not accept the 8(g) Notice by phone, mail or email.
4. Parties are required to submit a new form for each affected date and time. You are allowed to add multiple locations for the same date and time on a single form only.
5. Please be patient while submitting your 8(g) Notice to FMCS. Do not click the 'Submit' button more than once. Doing so may cause a duplicate submission and no confirmation page.
6. Please contact FMCS at clientservices@fmcs.gov if assistance is needed.

*** = required field**

Labor Organization’s Information				
Union Full Name* (drop down {DD} box FMCS database and “Other” option with text entry option)				
Union Unit Number* (Local, Lodge, District, Chapter, etc.)				
Address Line 1*	Address Line 2	City*	State* DD Box with 50 states listed	Zip Code*
Primary Function of Bargaining Unit Employees* (Nurses, etc.)				
Labor Organization’s Chief Negotiator or Business Agent				
First Name*	Last Name*		Business Email*	
Confirm Email*	Primary Phone*		Extension	
Strike, Picketing, or other Concerted Refusal to Work Information				

Action to be taken* (select one)				
<input type="checkbox"/> Picket Notice <input type="checkbox"/> Strike Notice <input type="checkbox"/> Work Stoppage				
Major Issue* (drop down {DD box} FMCS database and “Other (specify)” option with text entry option)				
Date* (DD date)		Time*		
<i>Parties are required to submit all locations affected (Add additional location button) (pop-up locations added are for the Date and Time listed above only)</i>				
Address Line 1*	Address Line 2	City*	State* DD Box with 50 states listed	Zip Code*
If you have an existing FMCS case number, enter it here		If you have an existing FMCS F7 notice submission confirmation number, enter it here		
Employer Information				
Employer Name* (Text box only now. In the future, drop down {DD box} FMCS database and “Other” option with text entry option)				
Address Line 1*	Address Line 2	City*	State* DD Box with 50 states listed	Zip Code*
Employer’s Chief Negotiator or Representative				
First Name*	Last Name*	Business Email*		
Confirm Email*	Primary Phone*	Extension		
Official Filing This Notice				
First Name*	Last Name*	Title*		
Business Email*	Confirm Email*			
Primary Phone*	Extension			

Privacy Act Statement. 29 U.S.C. § 172, et seq., authorize the FMCS to require the reporting of this information. The primary use of the information on this form is to allow FMCS officials to provide mediation services. Additional disclosures of the information on this form are available to view on our FMCS Case Records SORN. This information may be used by FMCS to contact parties concerning trainings, events, presentations, conferences, and other education opportunities and programs. This information will not be disclosed to any requesting person unless authorized by law. Failure to provide the requested information could result in FMCS’s delay or inability to provide services.