



Rhode Island Department of Labor and Training
 LABOR STANDARDS UNIT – BLDG. 70/2
 1511 Pontiac Avenue. P.O. Box 20390
 Cranston, RI 02920-0944

OFFICIAL USE ONLY:

Case Number: _____
 Date Received: _____
 Dated Closed: _____
 Examiner: _____

NON—PAYMENT OF WAGES COMPLAINT FORM

Complete both sides of this form, sign and return to the address above or email to DLT.LaborStandards@DLT.RI.Gov; **do not fax**. Type or print clearly. **Incomplete forms will be returned**. Complete ALL items to the best of your knowledge. Enclose any copies of documentation that may be relevant to your claim. Please notify this office immediately by mail if you have a change of address, phone number or have been paid.

EMPLOYEE INFORMATION:

1. First and Last Name: _____
 2. Last 4 Digits of your Social Security #: _____
 3. Address (Number & Street): _____
 City/Town: _____ State: _____ Zip Code: _____
 4. Home phone: _____ 5. Cell phone: _____ 6. Email: _____
 7. Title/Occupation or Type of Work Done: _____

EMPLOYMENT INFORMATION: (complaint will not be accepted unless this section is completed.)

8. Business Name: _____ 9. Business Phone: _____
 10. Business Address (Number & Street, **NOT P O Box**): _____
 Business City/Town: _____ State: _____ Zip Code: _____
 11. Other Business Name (s) that might be used by employer: _____
 12. Name of Person In Charge: _____ 13. Title: _____
 14. Did you work at business address listed above? Yes No
 If no, please provide the location where you did work: _____
 15. Hours per week: _____ 16. Wage Rate: _____
 17. Type of Wage: Hourly Salary Commission Other, please explain: _____
 18. Date hired: _____ 19. Date of separation: _____
 20. Reason for separation (layoff, quit, etc): _____
 21. Are you represented by an attorney? Yes No
 If yes, please provide the attorney's name: _____

22. Please check **all** the reason(s) why you are filing this claim:

- | | | |
|---|--|---|
| <input type="checkbox"/> Final paycheck not received | <input type="checkbox"/> Commission not received/incorrect | <input type="checkbox"/> Paid Sick/Safe Leave |
| <input type="checkbox"/> Vacation pay upon termination* | <input type="checkbox"/> Minimum wage | <input type="checkbox"/> Overtime wages |
| <input type="checkbox"/> No paystub | <input type="checkbox"/> Sunday or holiday premium pay | <input type="checkbox"/> Minimum shift |
| <input type="checkbox"/> Improperly classified as an Independent Contractor | <input type="checkbox"/> Bounced paycheck | <input type="checkbox"/> Illegal deductions |

* If checked, please provide a written copy of the vacation policy

23. Did you ask the employer for the money you believe is due? Yes No

If yes, who did you ask? Name: _____

Title: _____

If no, why not (please provide the reason(s) for not asking; be specific)?

24. Do you have a signed employment contract or independent contractor agreement? Yes No

If yes, please provide a copy with this claim form.

25. List the dates and hours for which you believe wages are due, and the amount you are claiming. Attach additional sheets if necessary and provide any relevant documentation to your claim.

Total Amount Claimed: \$ _____

I hereby certify that to the best of my knowledge and belief that this is a true statement of the facts relating to my complaint. I hereby assign all wages and penalties accruing because of their non-payment, and all liens securing them to the Rhode Island Director of Labor and Training to collect in accordance with the law.

Signature: _____ Date: _____

Print Name: _____

Minor child requires parent's signature: _____

IMPORTANT: This Division has jurisdiction over wage issues only. We cannot assist you in obtaining payment for time not worked, or for expenses, tax issues, pension plan issues or unemployment.