



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: _____
Date 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](mailto: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**

First and Last Name: \_\_\_\_\_  
 Last 4 Digits of your Social Security #: \_\_\_\_\_  
 Address (Number & Street): \_\_\_\_\_  
 City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Title/Occupation or Type of Work Done: \_\_\_\_\_

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

Business Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
 Business Address (Number & Street, **NOT P O Box**): \_\_\_\_\_  
 Business City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Other Business Name (s) that might be used by employer: \_\_\_\_\_  
 Name of Person In Charge: \_\_\_\_\_ Title: \_\_\_\_\_  
 Did you work at business address listed above? Yes No  
 If no, please provide the location where you did work: \_\_\_\_\_  
 Hours per week: \_\_\_\_\_ Wage Rate: \_\_\_\_\_  
 Type of Wage: Hourly Salary Commission Other (please explain) \_\_\_\_\_  
 Date Hired: \_\_\_\_\_ Date of Separation: \_\_\_\_\_  
 Reason for separation (layoff, quit, etc): \_\_\_\_\_  
 Are you represented by an attorney? Yes No  
 If yes, please provide the attorney's name: \_\_\_\_\_

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

- |  |                                   |                      |
|--|-----------------------------------|----------------------|
| Final paycheck not received                        | Commission not received/incorrect | Paid Sick/Safe Leave |
| Vacation pay upon termination*                     | Minimum wage                      | Overtime wages       |
| No paystub   | Sunday or holiday premium pay     | Minimum shift        |
| Improperly classified as an independent contractor | Bounced paycheck                  | Illegal deductions   |

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

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)?

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

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

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.**