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; **do not fax or email.** 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:

- ☐ Final paycheck not received
- ☐ Vacation pay upon termination*
- ☐ No paystub
- ☐ Improperly classified as an Independent Contractor
- ☐ Commission not received/incorrect
- ☐ Minimum wage
- ☐ Sunday or holiday premium pay
- ☐ Bounced paycheck
- ☐ Paid Sick/Safe Leave
- ☐ Overtime wages
- ☐ Minimum shift
- ☐ 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.