Employment Information Form

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

This report is authorized by Section 1 1 of the Fair Labor Standards Act. While you are not required to respond, submission of this information is necessary for the Division to schedule any compliance action. Your identity will be kept confidential to the maximum extent possible under existing law. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0001
Expires: 06-30-2010

1. Person Submitting Information

A. Name (Print first narne, middle initial, and last name)

Mr.

Miss

Mrs.

Ms.

B. Date

C. Telephone number:

Home:

Work:

D. Address: (Number, Street, Apt. No.)

(City, County, State, Zip Code)

E. Check one of these boxes

☐ Present employee of establishment ☐ Former employee of establishment ☐ Other _____

(Specify: relative, union, etc)

2. Establishment Information

A. Name of establishment/Name of Contact and Titie

B. Telephone Number

C. Address of establishment: (Number, Street)

(City, County, State, Zip Code)

D. Estimate number of employees

E. Does the firm have branches? ☐ Yes ☐ No ☐ Don't know

If "Yes", name one or two locations: _____

F. Sector: (Select One) ☐ Public agency ☐ Private for-profit ☐ Private non-profit

Nature of establishment's business: (For example; school, farm, hospital, hotel, restaurant, shoe store, wholesale drugs, manufactures stoves, coal mine, construction, trucking, etc.)

G. If the establishment has a Federal Government or federally assisted contract, check the appropriate box(es).

☐ Furnishes goods ☐ Furnishes services ☐ Performs construction ☐ Don't Know

H. Does establishment ship goods to or receive goods from other States?

☐ Yes (describe) _____ ☐ No ☐ Don't know

3. **Employment Informatilon** (Complete A, B, C, D, E, & F if present or former employee of establishment; otherwise complete F only), complete G only if a potential violation of the Family and Medical Leave Act)

A. Period employed (month, year)

From: _____

To: _____
(If still there, state present)

B. Date of birth if you were younger than 19, at any time while employed at this establishment

Month _____ Day _____ Year _____

C. Give your job titie and describe briefly the kind of work you do (or did)

(Continue on other side)

D. Frequency of payment (check appropriate box)

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other

Method of payment $ _____ (Rate) per _____ (Hour, week, month, etc.)

E. Enter in the boxes below the hours you usually work (or worked) each day and each week (less time off for meals)

M	T	W	T	F	S	S	Total

F. Check the appropriate box(es) and explain briefly in the space below the employment practices whichyou believe violate the Wage and Hour laws. (If you need more space use an additional sheet of paper and attach it to this form.)

☐ Does not pay the minimum wage (explain below)

☐ Does not pay proper overtime (explain below)

☐ Does not pay prevailing wage/fringe benefits for Federal Government or federally assisted contracts (explain below)

Approximate date government contract ends _____

☐ Violation of Migrant and Seasonal Agricultural Worker Protection ACt (explain below)

☐ Excessive deduction or discharge because of wage garnishment (explain below)

☐ Employs minors under minimum age for job, for excessive hours, or in illegal occupations (explain below)

☐ Violation of Family and Medical Leave Act (FMLA) (complete G below)

☐ Other (explain below)

Explanation: _____

G. **Family and Medical Leave Act (FMLA) Eligibility**

(i) Number of hours employee worked during 12 months prior to the start of FLMA leave _____

(ii) Employee works at a location where at least 50 or more employees are employed within 75 miles ☐ Yes ☐ No

(iii) Leave Reason (check one)

☐ Birth of a child ☐ Adoption or foster care placement ☐ Employee's serious health condition

☐ Care for a spouse, child or parent with a serious health condition

(Note: If you think it would be difficult for us to locate the establishment or where you live, give directions or attach map.)

Complaint Taken By:

Public Burden Statement

We estimate that it will take an average of 20 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Administrator, Wage and Hour Division,Room S3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**