

Employment Information Form



This report is authorized by Section 11 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. 1235-0021
Expires: xx-xx-xxxx

1. Person Submitting Information

A. Name (Print first name, 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 Title
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 Information (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 title and describe briefly the kind of work you do (or did)

D. Frequency of payment (check appropriate box)

Weekly Bi-Weekly Semi-Monthly Monthly Other

Method of payment \$ _____ per _____
 (Rate) (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 which you believe violate the Wage and Hour laws. (If you need more space use an additional sheet of paper and attach it to this form.)

- | | |
|---|---|
| <input type="checkbox"/> Does not pay the minimum wage (explain below) | <input type="checkbox"/> Excessive deduction or discharge because of wage garnishment (explain below) |
| <input type="checkbox"/> Does not pay proper overtime (explain below) | <input type="checkbox"/> Employs minors under minimum age for job, for excessive hours, or in illegal occupations (explain below) |
| <input type="checkbox"/> Does not pay prevailing wage/fringe benefits for Federal Government or federally assisted contracts (explain below)
Approximate date government contract ends _____ | <input type="checkbox"/> Violation of Family and Medical Leave Act (FMLA) (complete G below) |
| <input type="checkbox"/> Violation of Migrant and Seasonal Agricultural Worker Protection Act (explain below) | <input type="checkbox"/> 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.**