INDUSTRIAL COMMISSION OF ARIZONA
800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

EARNED PAID SICK TIME

Your Last Name:	First Name:	MI:	*Social Security Number:	Birth Date:
Address:		Apt. Number:	Email Address:	
City:	State: Zip Code:	Telephone No.	Cell Phone No.	Message No.

Company Name:	Telephone No.	Type of Business:
Address:		Suite Number:
City:	State: Zip Code:	Owner's Name:
Owner's Home Address (if available):		
Additional information (corporate name, address, phone number, email):		

EMPLOYMENT INFORMATION:

Your Job Title: _____Type of Work Performed: _____

Address where work was performed: _____

Start Date of Employment: _____ Last Date of Employment: _____

Your Rate of Pay: $ _____ ◯ Hourly ◯ Commission ◯ Other _____

How Often Were You Paid: ◯ Weekly ◯ Bi-Weekly ◯ Semi-Monthly ◯ Monthly _____

DATES EARNED PAID SICK TIME (EPST) VIOLATION OCCURED: _____

TOTAL DOLLAR VALUE OF EPST YOU ARE CLAIMING: _____

TOTAL NUMBER OF HOURS OF EPST YOU ARE CLAIMING:_____

COMPLAINT INFORMATION

Have you filed a civil suit or other complaint regarding this matter?..... ◯ Yes ◯ No
Are you currently working for this employer? ..... ◯ Yes ◯ No
Is the employer still in business? …..... ◯ Yes ◯ No
Do you have a copy of your employer's EPST policy? **IF YES, PROVIDE COPIES** ◯ Yes ◯ No
Do you have records of payment/and or paystubs? **IF YES, PROVIDECOPIES** ◯ Yes ◯ No
Do you possess any documentation regarding your absence?..... ◯ Yes ◯ No

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*Disclosing your social security number is voluntary. It will assist in the processing of your case. It will also be used by this agency in carrying out its other duties including, but not limited to, proper identification, law enforcement, and claim processing and program administration.

Additional Information/Narrative Description:

WHERE THE COMMISSION DETERMINES THAT YOUR NAME MUST BE DISCLOSED IN ORDER TO INVESTIGATE A COMPLAINT FURTHER, IT MAY DO SO ONLY WITH YOUR CONSENT.

Check One : ○ I do **NOT** want my name revealed to my employer.
○ My name **MAY BE** revealed to my employer

IF YOUR EARNED PAID SICK TIME CLAIM IS INCOMPLETE IT WILL BE RETURNED TO YOU. THIS WILL DELAY THE PROCESS AND NO FURTHER ACTION WILL BE TAKEN.

I hereby certify that this is a true statement to the best of my knowledge. I understand that acceptance of this claim by the Labor Department does not guarantee collections. I authorize the Department to receive monies due to me and to mail such monies at my own risk (checks will be mailed certified to your address listed on file).

Date: _____ Signature: _____