

Earned Paid Sick Time Claim Form

INDUSTRIAL COMMISSION OF ARIZONA
LABOR DEPARTMENT
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070
PHONE (602) 542-4515 FAX 602-542-8097

EARNED PAID SICK TIME

Case No. _____

(FOR OFFICE USE ONLY)

CLAIMANT INFORMATION:			
*Last Name:	*First Name:	MI:	*DOB:
*Address (including Apartment No., if applicable):		E-Mail Address:	
*City:	*State:	*Zip Code:	*Telephone Number:
		Cell Phone Number:	
The Labor Department will keep your name and identity confidential for as long as possible. However, IF THE LABOR DEPARTMENT DETERMINES THAT YOUR NAME MUST BE DISCLOSED IN ORDER TO INVESTIGATE YOUR CLAIM, YOUR NAME WILL ONLY BE DISCLOSED WITH YOUR CONSENT. If you do not agree to the release of your name, the Labor Department will not be able to issue a determination that requires your employer to compensate you for amounts that you may be owed. Pursuant to A.R.S. § 23-364(B), it is illegal for your employer to retaliate against you for filing this Earned Paid Sick Time Claim.			
*Check One Box:			
<input type="checkbox"/> I understand my right to confidentiality and AGREE that the Labor Department may release my name to my employer if necessary to investigate my complaint.			
<input type="checkbox"/> I understand my right to confidentiality and DO NOT want my name released to my employer. I understand that the Labor Department will not be able to issue a determination that requires my employer to compensate me for amounts that may be owed.			
*Select ONE preferred method of communication and service: <input type="checkbox"/> E-Mail (include e-mail address above) <input type="checkbox"/> U.S. Mail Note: You must promptly notify the Labor Department of any changes to your address, telephone number, or e-mail address.			
EMPLOYER INFORMATION:			
*Employer Business Name:	Supervisor:	*Telephone Number:	
*Address (including Suite No., if applicable):			
*City:	*State:	*Zip Code:	Owner's Name(s):
Owner's Mailing or E-Mail Address:			
Additional Information (business e-mail address, corporate name, additional business addresses, owner's cell phone number, etc.):			
EMPLOYMENT INFORMATION:			
*Job Title: _____		Type of Work Performed: _____	
Address Where Work Was Performed: _____			
*Start Date of Employment: _____		*Last Date of Employment: _____	
*Rate of Pay: \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Commission <input type="checkbox"/> Other _____			
How Often Were You Paid: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly			
COMPLAINT INFORMATION:			
*Violation Type: <input type="checkbox"/> Used earned paid sick time, but did not receive wages <input type="checkbox"/> Earned paid sick time not accrued properly			
<input type="checkbox"/> Employer has no earned paid sick time policy <input type="checkbox"/> Other: _____			
Were you an Independent Contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____			
What date(s) did you use earned paid sick time? _____			
How many hours of earned paid sick time did you use? _____			
How much money are you owed for the sick time? _____			
Note: If you wish to pursue an earned paid sick time retaliation claim, you must also complete the Retaliation Complaint Form.			

