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:

☐ I understand my right to confidentiality and **I AGREE** that the Labor Department may release my name to my employer if necessary to investigate my complaint.

☐ 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: ☐ E-Mail (include e-mail address above) ☐ 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 Name (as indicated on a paystub or tax form):	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: $_____ ☐ Hourly ☐ Commission ☐ Other _____

How Often Were You Paid: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

COMPLAINT INFORMATION:

*Violation Type: ☐ Used earned paid sick time, but did not receive wages ☐ Earned paid sick time not accrued properly ☐ Employer has no earned paid sick time policy ☐ Other: _____

Were you an Independent Contractor? ☐Yes ☐ 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.

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***Provide a detailed statement of the events that occurred, including all information supporting your claim:**

NOTE: SUBMITTING AN INCOMPLETE EARNED PAID SICK TIME CLAIM FORM MAY DELAY OR RESULT IN DISMISSAL OF YOUR CLAIM.

I hereby certify that this is a true statement to the best of my knowledge and further certify that the above-listed information is complete and accurate. I understand that acceptance of this Earned Paid Sick Time Claim by the Labor Department does not guarantee an award or collections of an award. I authorize the Labor Department to receive monies due to me and to mail such monies at my own risk. (Checks may be picked up or will be mailed to the address on file at the Labor Department.)

*I have supporting documents and evidence related to my Earned Paid Sick Time Claim, which may include relevant pay stubs ☐ **Yes** ☐ **No.** If "Yes," you must promptly submit your supporting documents and evidence to the Labor Department by U.S. Mail (P.O. Box 19070, Phoenix, AZ 85005-9070), Fax (602-542-8097), or e-mail (Laborinv@azica.gov).

*Date: _____ *Claimant's Name: _____/_____
Print Signature

*** = Required Field**