BEFORE FILING A WAGE CLAIM
PLEASE READ THESE INSTRUCTIONS CAREFULLY

IMPORTANT: By filing this claim with the Wage and Hour Program, you are electing a remedy which may prevent you from pursuing this claim elsewhere, including civil court

A wage claim may be filed in person from 8 a.m. to 5 p.m., Monday through Friday, at the street address below:

530 W. Allegan St.
Lansing, MI 48933

or by mailing the completed form to:

P.O. Box 30476
Lansing, MI 48909-7976

You may file online on our website at: www.michigan.gov/wagehour

DO NOT FILL OUT THE EMPLOYMENT WAGE COMPLAINT FORM IF:

- You did not perform work in Michigan.
- Your employer has filed bankruptcy or has been determined bankrupt. If so, you will need to contact the Bankruptcy Court for further instructions.
- You were a volunteer, subcontractor, owner/operator, or self–employed.
- You have filed a law suit against the employer for the same wage or fringe benefit issues.
- You have already received a civil court judgment involving the same wage or fringe benefit issues.
- You do not know your employer's complete business name and mailing address.
- You are trying to obtain a W-2 or 1099 tax form, contact the Internal Revenue Service at 1-800-829-1040.
- Your claim for wages and/or fringe benefits earned and due is beyond the 12-month statute of limitations.
- Your claim for minimum wage or overtime wages is beyond the 3-year statute of limitations.

PROVIDE ALL THE REQUESTED INFORMATION BELOW AND COMPLETELY FILL OUT THE EMPLOYMENT WAGE COMPLAINT FORM WITH:

- Your name, complete mailing address and telephone number, **and**
- The complete name and mailing address of your employer, **and**
- Your reason for filing the claim **including** the period claimed **and** total amount claimed for **each** issue claimed.
- Copies of documents as evidence should be included with your claim, such as an employment contract, wage agreement, collective bargaining agreement, commission statements, invoices, time records, list of hours worked, check stubs, W-2, written fringe benefit (vacation pay, sick pay, holiday pay, paid time off, bonus, expense reimbursement) policy or contract.

NOTE: Filing this complaint does not guarantee payment or a finding in your favor**.**
An incomplete form will be returned to you.

INVESTIGATION PROCESS

- The claim is assigned to an investigator to review for completeness and determine if the claim is within the authority of the Wage & Hour Program. If the claim is within the Program's authority, the parties to the claim are notified by mail that the claim is opened and the claim is being investigated.
- All Investigators work on a first-in, first out basis and will thoroughly investigate and resolve the claim in compliance with the law when it comes up in rotation on his or her caseload.
- The time required to complete an investigation depends on the cooperation of the parties involved in the process and the complexity of the claim.
- You will be contacted if additional information is required and upon conclusion of the investigation.

YOU MUST NOTIFY THE PROGRAM IF:

- You receive any payment directly from the employer.
- You change your address or contact telephone/cell phone number.
- **Failure to report this information will delay the investigation of your complaint.** Also, the Program can not mail any payments received from the employer to you without your current address.

CLAIM NUMBER:

EMPLOYMENT WAGE COMPLAINT

Michigan Department of Licensing and Regulatory Affairs
Michigan Occupational Safety and Health Administration
Wage and Hour Program

Mailing Address:	Street Address:
P.O. Box 30476	530 W. Allegan St.
Lansing, MI 48909-7976	Lansing, MI 48933
Toll Free: 1-855-464-9243	Facsimile: 517-322-6352

Website: www.michigan.gov/wagehour

IMPORTANT: By filing this claim with the Wage & Hour Program, you are electing a remedy which may prevent you from pursuing this claim elsewhere, including civil court.

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available, upon request, to individuals with disabilities for the purpose of accessibility under state and federal law. Please call 517.284.7800 to make your needs known to this agency.

AUTHORITY: 1978 PA 390, 2014 PA 138
COMPLETION: VOLUNTARY
PENALTY: NONE

EMPLOYEE INFORMATION. Please Print

LAST NAME, FIRST NAME, MIDDLE INITIAL .		LAST 4 NUMBERS OF SOCIAL SECURITY NUMBER:
ADDRESS (STREET NUMBER AND NAME):		BIRTH DATE:
CITY, STATE, ZIP:		COUNTY:
EMAIL ADDRESS:	PRIMARY TELEPHONE NUMBER:	DAYTIME TELEPHONE NUMBER:

CONTACT INFORMATION FOR SOMEONE WHO WILL ALWAYS KNOW HOW TO REACH YOU:

ADDRESS WHERE YOU WORKED (STREET NUMBER AND NAME):

CITY, STATE, ZIP:	COUNTY:

START DATE OF EMPLOYMENT (MONTH/DAY/YEAR):	**LAST DATE WORKED (MONTH/DAY/YEAR):**
EMPLOYMENT STATUS: ☐ QUIT ☐ DISCHARGED ☐ STILL EMPLOYED	**HOW OFTEN WERE YOU PAID?** ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY

LIST YOUR RATE OF PAY. PROVIDE A COPY OF YOUR CHECK STUB.	PER HOUR $	SALARY $	COMMISSION $	PIECE RATE / OTHER $

IF SALARIED, HOW MANY DAYS/HOURS WERE YOU REQUIRED TO WORK EACH WEEK OR PAY PERIOD?	**WHAT WAS/IS YOUR JOB TITLE?**

EMPLOYER INFORMATION. Please Print

BUSINESS NAME:		TYPE OF BUSINESS (IF KNOWN):
BUSINESS ADDRESS (STREET NUMBER AND NAME):		
CITY, STATE, ZIP:		COUNTY:
TELEPHONE NUMBER:	FAX NUMBER:	EMAIL OR WEBSITE ADDRESS OF EMPLOYER (IF KNOWN):
NAME OF PERSON IN CHARGE OF DAY-TO-DAY OPERATIONS:		LIST THE APPROXIMATE NUMBER OF EMPLOYEES:

WAS YOUR EMPLOYMENT GOVERNED BY MORE THAN ONE EMPLOYER? IF SO, LIST BELOW THE ADDITIONAL EMPLOYER'S NAME, ADDRESS, CITY, STATE, ZIP CODE, AND TELEPHONE NUMBER OR ATTACH AN ADDITIONAL SHEET LISTING THE INFORMATION.

THIS CLAIM WILL BE RETURNED IF A CLAIM AMOUNT AND A CLAIM PERIOD ARE NOT PROVIDED.
Filing this complaint does not guarantee payment or a finding in your favor.
Please provide documentation to substantiate your claim, for example, pay stubs, time sheets, written policies, etc.

Your Reason for Filing this Claim	Period of Claim Month/Day/Year to Month/Day/Year			Calculate the Amount Claimed for Each Selection Attach additional sheets if necessary	Amount Claimed
WAGES				Example: Hourly = 80 hours X $10.00/hr.	$800.00
Hourly					
Salary					
Commissions (Provide list of commissions)					
Piece Rate / Other					
Unauthorized Deductions					
FRINGE BENEFITS (Provide written policy or contract)				Example: Vacation Pay =80 hours X $10.00/hr.	$800.00
Vacation Pay					
Paid Time Off					
Holiday Pay					
Sick Pay					
Expense Reimbursement (Provide list of expenses)					
Bonus (List type of Bonus)					
MINIMUM WAGE				Example: MW = 40 hours X $8.15/hr.	$326.00
OVERTIME				Example: OT = 100 OT hours X $15.00/OT hr.	$1,500.00
TOTAL GROSS (before tax deductions) AMOUNT CLAIMED					$

Are you filing a complaint for pay stubs or wage statements you did not receive? ☐ **Yes** ☐ **No**

If yes, please list dates you did not receive a pay stub or wage statement:

PLEASE ANSWER THE FOLLOWING	YES	NO
HAVE YOU FILED A LAW SUIT AGAINST THE EMPLOYER ON THE ISSUES OF THIS CLAIM?		
IF CLAIMING FRINGE BENEFITS, WAS A WRITTEN POLICY OR CONTRACT IN EFFECT DURING YOUR EMPLOYMENT? IF YES, PLEASE PROVIDE A COPY OF THE WRITTEN POLICY OR CONTRACT.		
DOES THE BUSINESS MAKE MORE THAN $500,000/YEAR OR TRANSPORT GOODS OUTSIDE OF MICHIGAN?		
WAS YOUR EMPLOYMENT COVERED BY A UNION CONTRACT? IF YES, PLEASE SUBMIT A COPY OF THE CONTRACT.		

CERTIFICATION: I certify to the best of my knowledge and belief that this is a true statement of wages and/or fringe benefits due me. I will inform the department if any of the following occur: change of name, address, and/or telephone number for myself and/or employer, or a direct payment and/or settlement of the claim.

Signature of Complainant:	**Date:**