



**EMPLOYMENT WAGE COMPLAINT**  
 Michigan Department of Labor & Economic Growth  
 Wage & Hour Division  
 7150 Harris Drive, Box 30476  
 Lansing, MI 48909-7976  
 Phone: (517) 322-1825  
 Website: [www.michigan.gov/wagehour](http://www.michigan.gov/wagehour)

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

THE DEPARTMENT OF LABOR & ECONOMIC GROWTH WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, HANDICAP OR POLITICAL BELIEFS.

AUTHORITY: ACT 390, PUBLIC ACTS OF 1978, AS AMENDED; ACT 154, PUBLIC ACTS OF 1964, AS AMENDED  
 COMPLETION: VOLUNTARY  
 PENALTY: NONE

<b>EMPLOYEE INFORMATION</b> <i>Please print your name below.</i> <i>Please sign your name in the signature block on the back of this form</i>		<b>EMPLOYER INFORMATION</b>	
LAST NAME, FIRST NAME, MIDDLE INITIAL		BUSINESS NAME:	
ADDRESS (STREET NUMBER AND NAME):		BUSINESS ADDRESS (STREET NUMBER AND NAME): <i>CLAIM WILL BE RETURNED IF EMPLOYER ADDRESS IS NOT PROVIDED</i>	
CITY, STATE, ZIP:		CITY, STATE, ZIP:	
COUNTY:		COUNTY:	
BIRTH DATE:	SOCIAL SECURITY NUMBER:	<b>IF THE ADDRESS SHOWN ABOVE IS NOT CURRENT FOR THE EMPLOYER, WHERE CAN THE EMPLOYER BE CONTACTED?</b>	
ADDRESS WHERE YOU WORKED (STREET NAME AND NUMBER, CITY, STATE, AND ZIP CODE)			
EMAIL ADDRESS:		EMAIL OR WEBSITE ADDRESS (IF KNOWN):	
HOME TELEPHONE NUMBER: ( )		TELEPHONE NUMBER: ( )	
TELEPHONE NUMBER WHERE YOU CAN BE CONTACTED BETWEEN 8 AM AND 5 PM, MONDAY THRU FRIDAY: ( )		NUMBER OF EMPLOYEES:	
		PERSON IN CHARGE OF DAY-TO-DAY OPERATIONS:	

**FOR OFFICE USE ONLY**

CLAIM NUMBER:	ACTION:	REVIEWER:	DATE:
AMOUNT, NATURE AND DATES OF CLAIM:		CC:	

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Amount Claimed - Claim will be returned if an amount is not provided.

How did you determine the dollar amount of wages, overtime, and/or fringe benefits due you?  
 Use this area to show your math (example: \$8.00 x 5 hrs = \$40.00). Attach an additional sheet if needed.

**TOTAL DOLLAR AMOUNT CLAIMED:**  
 \$

Dates you earned the pay claimed - FROM: TO:

Start date of employment: Last date worked:

Employment Status:  QUIT  DISCHARGED  STILL EMPLOYED

If discharged, state reason given by employer?

RATE OF PAY	HOURLY \$	SALARY \$	COMMISSIONS \$	OTHER \$
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**If salaried, how many days did you work each week or pay period?**

How often were you paid?  WEEKLY  BI-WEEKLY  SEMI-MONTHLY  MONTHLY

What type of work did you do?

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

	YES	NO
Have you asked for your wages or fringe benefits?		
Have you kept a record of hours worked? If yes, submit a copy.		
Have you kept a record of deduction slips, wage statements or pay stubs? If yes, submit a copy.		
If claiming vacation pay, holiday pay and/or sick pay, is there a written contract/policy? If yes, provide a copy.		
Are you filing this claim because the employer did not pay minimum wage and/or time & one-half for hours worked over 40/week?		
Does the business make more than \$500,000/year or transport goods outside of Michigan?		
Does the business have more than 15 employees?		
Were you in a union or covered by a union contract?		
Did your employer regulate your hours?		
Did your employer tell you how to perform your work?		
Did your employer make deductions for taxes?		
Did you receive a: <input type="checkbox"/> W-2 or <input type="checkbox"/> IRS FORM 1099? If yes, submit a copy.		

**Provide any additional information you may have on an attached sheet of paper. Attach copies of any document which supports your claim such as: an employment contract, commission statements, invoices, time records, check stubs, written fringe benefit policy or a contract.**

**CERTIFICATION:** I certify that to the best of my knowledge and belief, this is a true statement of wages or fringe benefits due me. I understand that my claim will be investigated and there is no guarantee that the wages and/or fringe benefits will be found due. I will inform the department if any of the following occur: change of name, address, and/or telephone number for myself; or change of employer address; or direct payment and/or settlement of claim.

SIGNATURE OF CLAIMANT: DATE: