

WAGE AND HOUR DIVISION (WHD) COMPLAINT FORM

The Complaint Form must be completed in full to avoid delay or dismissal.

Completed forms can be filed Online, fax, mail or in-person by appointment:

- **Online (fastest method):** www.michigan.gov/wageclaim
- **Fax:** 517-763-0110
- **Mail:** Wage & Hour Division, P.O. Box 30476, Lansing, MI 48909-7976
- **In Person-- Lansing or Detroit BY APPT ONLY**
320 S. Walnut St., Lansing, MI 48933 (Mon through Friday; 8am- 4pm)
3026 W. Grand Blvd., Suite 2-750, Detroit, MI 48202 (Mon and Wed only; 8:30am- 4pm)

A. COMPLETE AND RETURN THE ENTIRE PACKET INCLUDING ALL THE FOLLOWING INFORMATION:

1. Your Name, Complete Mailing Address, Email and Telephone number (preferably cell/text).
2. Employer/ Company Name with Mailing address including City, State and Zip.
3. Employer Representative's Name, title/position, email and phone number.
4. **Reason for each claim including time frame and total amount for each claim.** (See claim types below).

B. CLAIM(S) MAY BE DISMISSED OR REJECTED IF:

5. Work was performed OUTSIDE of Michigan.
6. Employer has filed or been deemed Bankrupt. *(If so, contact the bankruptcy court.)*
7. You failed to provide a valid Company Name, Mailing address, Company Representative with email or phone.
8. Complaint form is incomplete or missing information or documents to support each claim.
9. Complaint was filed after the applicable filing deadline for the alleged claim (see claim list below)
10. You filed a separate lawsuit against the employer for the same wage or benefit allegations or claim.
11. Complaints filed under Act 390 may prevent the filing of a different action such as a separate lawsuit.

C. CLAIM TYPES & FILING DEADLINES (Check each claim that applies to your complaint):

12. **PMLA - Paid Medical Leave** | [Paid Medical Leave Act FAQ](#) Filing Deadline: 6 Months
13. **ESTA - Earned Sick Time** | [Earned Sick Time Act FAQ](#) Filing Deadline: 3 years
14. **Minimum Wage & Overtime** | [Minimum Wage and Overtime FAQ](#) Filing Deadline: 3 Years
15. **Youth Employment (Act 90 Monetary Only)** | [Youth Employment Standards Act Information](#)

D. CLAIMS ON DIFFERENT FILING FORMS

16. *Youth Employment Standards Complaints* [Click Here](#)
17. *Prevailing Wage on Construction Projects* [Click Here](#)

E. CLAIMS EXPLANATION SEE BELOW (FINAL PAGE)

18. Provide a short narrative with copies of documents to support each claim.

F. CASE PROCESSING:

19. Once filed, a complaint is reviewed for the possible claim(s) that fall within the WHD's jurisdiction.
20. Parties will receive via email a case initiation letter listing the alleged claim(s) that will be investigated.
21. The time required for WHD to process a case will depend on various factors including a party's cooperation in submitting necessary information and the complexity of the underlying claim(s).
22. You will be contacted if additional information is required and at the conclusion of the investigation stage.

G. YOU MUST PROMPTLY NOTIFY THE DIVISION OF:

23. Any payments you receive regarding your claim.
24. Any changes to your mailing address, email, or telephone/cell number.

Failure to timely update this information may delay or stop the investigation of your claim.

WAGE AND BENEFIT COMPLAINT FORM MICHIGAN DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY WAGE AND HOUR DIVISION EMAIL: WHCLAIM@MICHIGAN.GOV MAILING ADDRESS: P.O. Box 30476 LANSING, MI 48909-7976 TOLL FREE: 1-855-464-9243 WEBSITE: WWW.MICHIGAN.GOV/WAGEHOUR		IMPORTANT: IF FILING THIS COMPLAINT UNDER 1978 PA 390, YOU ARE ELECTING A REMEDY WHICH MAY PREVENT YOU FROM PURSUING THIS CLAIM ELSEWHERE. LEO 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, 2018 PA 337 and PA 338 COMPLETION: VOLUNTARY PENALTY: NONE	
1. EMPLOYEE/WORKER/CLAIMANT DETAILS (PLEASE PRINT)			
LAST NAME, FIRST NAME, MIDDLE INITIAL		LAST 4 DIGITS OF SSN:	
ADDRESS (STREET NUMBER AND NAME):		BIRTH DATE:	
CITY, STATE, ZIP:		COUNTY:	
EMAIL ADDRESS:	PRIMARY PHONE (CELL/ LANDLINE):	ALTERNATE PHONE (CELL/ LANDLINE):	
CONTACT INFORMATION FOR SOMEONE WHO WILL KNOW HOW TO REACH YOU: (NAME, PHONE, RELATIONSHIP)			
2. EMPLOYER/BUSINESS DETAILS (PLEASE PRINT)			
NAME:		TYPE OF BUSINESS (IF KNOWN):	
ADDRESS (STREET NUMBER AND NAME):			
CITY, STATE, ZIP:		COUNTY:	
BUSINESS PHONE NUMBER:	FAX NUMBER:	COMPANY/BUSINESS WEBSITE (IF KNOWN):	
3. EMPLOYER REPRESENTATIVE DETAILS (PLEASE PRINT)			
NAME:		TITLE/POSITION:	
EMAIL ADDRESS:	PHONE 1: (CELL OR LANDLINE)	PHONE 2: (CELL OR LANDLINE)	
4. LOCATION WHERE YOU WORKED – ADDRESS :			
STREET NUMBER AND NAME:			
CITY, STATE, ZIP:		COUNTY:	
5. DATES OF EMPLOYMENT:			
START DATE OF EMPLOYMENT (MONTH/DAY/YEAR):		LAST DATE WORKED (MONTH/DAY/YEAR):	
EMPLOYMENT STATUS: <input type="checkbox"/> QUIT <input type="checkbox"/> DISCHARGED <input type="checkbox"/> STILL EMPLOYED		HOW OFTEN WERE YOU PAID? <input type="checkbox"/> WEEKLY <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> SEMIMONTHLY <input type="checkbox"/> MONTHLY	
LIST YOUR RATE OF PAY. PROVIDE A COPY OF A RECENT CHECK STUB.	PER HOUR \$	SALARY \$	COMMISSION \$
			PIECE RATE / OTHER \$
IF SALARIED, HOW MANY DAYS/HOURS WERE YOU REQUIRED TO WORK EACH WEEK?	# OF EMPLOYEES (APPROX.)	WHAT WAS/IS YOUR JOB TITLE?	

COMPLAINT MAY BE RETURNED IF THE CLAIM AMOUNT(S) AND TIME PERIOD(S) ARE MISSING.

FILING THIS COMPLAINT DOES NOT GUARANTEE PAYMENT OR A FINDING IN YOUR FAVOR.

PLEASE PROVIDE DOCUMENTATION TO SUBSTANTIATE YOUR CLAIM, FOR EXAMPLE, PAYSTUBS, 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)					
EARNED SICK TIME			EXAMPLE: MEDICAL LEAVE =80 HOURS X \$10.00/HR	\$800.00	
MINIMUM WAGE			EXAMPLE: MW = 40 HOURS X \$9.45/HR.	\$378.00	
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 THAT YOUR EMPLOYER DID NOT ALLOW YOU TO USE EARNED SICK TIME? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, PLEASE LIST DATES YOU WERE NOT ALLOWED TO USE YOUR EARNED SICK TIME:					
ARE YOU FILING A COMPLAINT FOR PAYSTUBS OR WAGE STATEMENTS YOU DID NOT RECEIVE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, PLEASE LIST DATES YOU DID NOT RECEIVE A PAYSTUB OR WAGE STATEMENT:					
PLEASE ANSWER THE FOLLOWING					
				YES	NO
HAVE YOU FILED A LAWSUIT AGAINST ANY EMPLOYER ON THE SAME ISSUES OF THIS CLAIM?					
IF CLAIMING FRINGE BENEFITS, WAS A WRITTEN POLICY OR CONTRACT IN EFFECT DURING YOUR EMPLOYMENT? IF YES, PROVIDE A COPY OF THE WRITTEN POLICY OR CONTRACT.					
IS/WAS YOUR EMPLOYMENT COVERED BY A UNION CONTRACT? IF YES, SUBMIT A COPY OF THE CONTRACT.					

PLEASE EXPLAIN THE NATURE OF YOUR CLAIM(S):

PROVIDE A SHORT NARRATIVE AND INCLUDE COPIES OF DOCUMENTS TO SUPPORT EACH CLAIM (E.G., EMPLOYMENT CONTRACT, WAGE AGREEMENT, COLLECTIVE BARGAINING AGREEMENT, COMMISSION STATEMENTS, INVOICES, TIME RECORDS, LIST OF HOURS WORKED, W-2s, CHECK STUBS, WRITTEN FRINGE BENEFIT POLICY OR CONTRACT REGARDING VACATION PAY, SICK PAY, HOLIDAY PAY, PAID TIME OFF, BONUS, EXPENSE REIMBURSEMENT)

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 EMPLOYEE/WORKER/CLAIMANT:

DATE: