

CLEAR

PRINT

# Initial Report or Claim

FOR OFFICE USE ONLY

Taken by:	Case#:	Date filed:
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**IS THIS CLAIM RELATED TO COVID-19?** NO  YES   
 If yes, explain: Business shut down Business layoff Sick leave unpaid/denied Exclusion pay unpaid  
 Other (specify):

## PRELIMINARY QUESTIONS

1. Is your claim about a <b>public works project</b> ? [If your answer is "YES," STOP here, DO NOT FILL OUT THIS FORM, and fill out the "PW-1" claim form instead. If your answer is "NO," proceed with this form.]
2. Have you filed a <b>retaliation complaint</b> against your employer with the Labor Commissioner? <input type="checkbox"/> YES, on: ____ / ____ / ____ <input type="checkbox"/> NO [If you have been retaliated against, you may file a retaliation complaint by filling out another form, "RCI 1 Form"] Month      Day      Year
3. Is there a <b>union contract covering your employment</b> ? YES [If "YES," attach a copy of the Collective Bargaining Agreement.] NO
4. Are other employees also filing wage claims against your employer? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> I DON'T KNOW

## Part 1 : LANGUAGE ASSISTANCE & REPRESENTATION

5a. Do you need an interpreter? YES      NO	5b. If you checked "YES" to Box 5a, enter the language needed		
6a. If you are being assisted with your claim by a lawyer or other advocate, enter your ADVOCATE'S NAME and ORGANIZATION	6b. ADVOCATE'S PHONE (      )		
6c. Your ADVOCATE'S MAILING ADDRESS (Number, Street, Floor, Suite)	CITY	STATE	ZIP CODE

## Part 2 : YOUR INFORMATION

7. Your FIRST NAME	8. Your LAST NAME	9. HOME PHONE (      )	10. OTHER PHONE (      )	11. BIRTH DATE
11a. Your EMAIL ADDRESS				
12. Your MAILING ADDRESS (Street Number, Street Name, Apartment Number)		CITY	STATE	ZIP CODE

## Part 3 : CLAIM FILED AGAINST ( EMPLOYER INFORMATION)

13. EMPLOYER / BUSINESS NAME(S)		14. EMPLOYER'S VEHICLE LICENSE PLATE #	15. EMPLOYER PHONE (      )	
		15a. EMPLOYER'S EMAIL ADDRESS		
16. ADDRESS of EMPLOYER / BUSINESS (Street Number, Street Name, Floor, Suite):		CITY	STATE	ZIP CODE
17. ADDRESS where you worked, if different from Box 16 (Number, Street, Floor, Suite):		CITY	STATE	ZIP CODE
18. NAME of PERSON IN CHARGE (First Name, Last Name)		19. JOB TITLE / POSITION of PERSON IN CHARGE		
20. TYPE OF BUSINESS	21. TYPE OF WORK PERFORMED	22. TOTAL NUMBER OF EMPLOYEES	23. EMPLOYER STILL IN BUSINESS? YES      NO      DON'T KNOW	
24. Check which box describes your employer, if you know: <input type="checkbox"/> CORPORATION <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> LLC <input type="checkbox"/> LLP				



**Part 6 : PAYMENT OF WAGES**

32. Were you paid or promised a <b>FIXED amount of wages per pay period</b> , no matter how many hours you worked (for example, \$400 per week, regardless of how many hours you worked)? <b>YES</b> <b>NO</b> I was paid \$ _____ per      day      week      every 2 weeks      month      semi-monthly  I was promised \$ _____ per      day      week      every 2 weeks      month      semi-monthly	
33a. Were you an <b>HOURLY</b> employee? <b>YES</b> <b>NO</b> I was paid \$ _____ per hour.  I was promised \$ _____ per hour.	33b. If you were an <b>HOURLY</b> employee, were you paid or promised <b>more than one hourly rate</b> (based on the hours you worked or different job tasks)? <b>YES</b> <b>NO</b>  If YES, please specify:
34. Were you paid by <b>PIECE RATE</b> ?      YES      NO	35. Were you paid by <b>COMMISSION</b> ?      YES      NO

**Part 7 : WAGES, COMPENSATION & PENALTIES OWED**

36. CLAIMS (Check all boxes below that apply)	CLAIM PERIOD: START DATE (Month/ Day/ Year)	CLAIM PERIOD: END DATE (Month/ Day/ Year)	AMOUNT EARNED / CLAIMED
<input type="checkbox"/> REGULAR WAGES (for non-overtime hours)			\$
<input type="checkbox"/> OVERTIME WAGES (including double time)			\$
<input type="checkbox"/> MEAL PERIOD WAGES			\$
<input type="checkbox"/> REST PERIOD WAGES			\$
<input type="checkbox"/> SPLIT SHIFT PREMIUM			\$
<input type="checkbox"/> REPORTING TIME PAY			\$
<input type="checkbox"/> COMMISSIONS ***			\$
<input type="checkbox"/> VACATION WAGES ***			\$
<input type="checkbox"/> BUSINESS EXPENSES			\$
<input type="checkbox"/> UNLAWFUL DEDUCTIONS			\$
<input type="checkbox"/> PAID SICK LEAVE			\$
<input type="checkbox"/> PAID SICK LEAVE Supplemental Paid Sick Leave			
<input type="checkbox"/> OTHER [provide separate explanation]			\$
<b>ENTER SUBTOTAL (add all Amounts Earned/Claimed):</b>			\$
<b>ENTER TOTAL AMOUNT PAID:</b>			\$
<b>GRAND TOTAL OWED [Subtotal minus Total Amount Paid]:</b>			\$
37. Check box(es) if you are claiming: <ul style="list-style-type: none"> <li><input type="checkbox"/> Waiting time penalties [Labor Code §203]</li> <li><input type="checkbox"/> Penalties for "bounced" checks (checks issued with insufficient funds) [Labor Code §203.1]</li> <li><input type="checkbox"/> Penalties for late payment wages [Labor Code §210]</li> <li><input type="checkbox"/> Liquidated damages for late payment wages [Labor Code §1194.2]</li> </ul>			

*The amounts claimed are based on my best estimates at this time and may be adjusted based on further information, or based on assistance with my claim provided by DLSE.*

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_