

## INTAKE FORM - SICK LEAVE COMPLAINT

Thank you for contacting the New York City Department of Consumer Affairs (DCA). Please complete the questions below. Clearly print or type your answers to each question. If a question does not apply to you, please mark N/A or Not Applicable.

If you have any questions about this form or would prefer to have a staff member help you complete the form, please contact DCA at [PaidSickLeave@dca.nyc.gov](mailto:PaidSickLeave@dca.nyc.gov), call (212) 436-0255 or (212) 436-0258, or visit DCA at the address below. If you prefer to use a language other than English, we can provide free translation assistance. You can submit the completed form in the following ways:

- Email: [PaidSickLeave@dca.nyc.gov](mailto:PaidSickLeave@dca.nyc.gov) OR
- Mail or hand deliver to: New York City Department of Consumer Affairs, Attn: Paid Sick Leave Division, 42 Broadway, 11th Floor, New York, NY 10004

After DCA receives your completed form, we will contact you within five business days to gather any additional information we need or to notify you what action we will be taking.

<b>How do you want DCA to help?</b>							<input type="checkbox"/> Help me resolve my complaint with my employer.		<input type="checkbox"/> Investigate an employer that I believe is violating the law.		
DCA will attempt to let you know if we must identify you to your employer in order to resolve your complaint or as required by law.											
<b>YOUR CONTACT INFORMATION</b>											
First Name <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.			M.I.	Last Name			Primary Language Used:				
Address (Building Number, Street Name, Apartment/Suite/Other)											
City		State		ZIP Code		Borough					
Phone Number 1 (Primary)			Phone Number 2 (Secondary)			Email Address					
By providing your email address, you consent to receive communications electronically from the Department of Consumer Affairs (DCA), and you affirm that the email listed is a reliable form of communication for you.											
<b>EMPLOYMENT INFORMATION</b>											
Employer							Primary Language Used in Workplace:				
Address Where You Work (Building Number, Street Name, Apartment/Suite/Other)											
City		State		ZIP Code		Borough					
Employer Still in Business? <input type="checkbox"/> Yes <input type="checkbox"/> No			Employer Hours of Operation			Your Job Title/Function					
Name of Supervisor or Manager			Supervisor/Manager Phone Number			Supervisor/Manager Email Address					
Number of Employees:	<input type="checkbox"/> 1- 4 Employees		<input type="checkbox"/> 5-19 Employees		<input type="checkbox"/> 20-99 Employees		<input type="checkbox"/> 100-499 Employees		<input type="checkbox"/> 500+ Employees		
Industry:	<input type="checkbox"/> Education		<input type="checkbox"/> Government		<input type="checkbox"/> Health Care		<input type="checkbox"/> Hospitality/Hotels		<input type="checkbox"/> Industrial/Manufacturing		<input type="checkbox"/> Nonprofit
<input type="checkbox"/> Professional Services		<input type="checkbox"/> Restaurant/Food Service		<input type="checkbox"/> Retail		<input type="checkbox"/> Grocery		<input type="checkbox"/> Construction		<input type="checkbox"/> Other	
1. On what date did you start working for your employer?						_____ / _____ / _____ (MM/DD/YY)					
2. On average, how many hours a week do you work for this employer?											
3. Do you perform work for your employer in New York City? (ONLY Bronx, Brooklyn, Manhattan, Queens, Staten Island)						<input type="checkbox"/> Yes		<input type="checkbox"/> No			
4. Are you still working for your employer?						<input type="checkbox"/> Yes		<input type="checkbox"/> No			
5. If you are <i>not</i> still working for your employer, please select the reason.						<input type="checkbox"/> Resigned/Quit		<input type="checkbox"/> Discharged/Fired		<input type="checkbox"/> Laid Off	
6. If you are <i>not</i> still working for your employer, what was your last day of work?						_____ / _____ / _____ (MM/DD/YY)					

**PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US DETERMINE IF YOU ARE COVERED BY NEW YORK CITY'S EARNED SICK TIME ACT (PAID SICK LEAVE LAW).**

1. Are you a member of a union?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Are you a government employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Are you part of a federal college work study program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Are you a physical therapist, occupational therapist, speech language pathologist, or audiologist licensed by the New York State Department of Education?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Are you part of a Work Experience Program (WEP)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Are you paid as a part of a scholarship program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Are you an independent contractor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
8. Are you a domestic worker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know

**COMPLAINT INFORMATION**

1. Do you think your employer has violated New York City's Paid Sick Leave Law?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. If Yes, on what date do you believe your employer violated the law? _____ / _____ / _____ (MM/DD/YY)		
3. Please indicate which of the following ways your employer violated New York City's Paid Sick Leave Law. Check all that apply.		

<input type="checkbox"/> Not allowing me to use sick leave	<input type="checkbox"/> Not compensating me correctly for sick leave	<input type="checkbox"/> Not allowing me to carry over sick leave from one year to the next
<input type="checkbox"/> Requiring me to find a replacement worker	<input type="checkbox"/> Requiring me to make up hours missed	<input type="checkbox"/> Requiring me to provide medical documentation
<input type="checkbox"/> Retaliating against me for requesting sick leave, using sick leave, or filing a complaint	<input type="checkbox"/> Not providing me with the Notice of Employee Rights	<input type="checkbox"/> Other

4. In your own words, please describe what happened. Use additional sheets, if necessary.

5. Have you tried to resolve your complaint with your employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. What type of relief are you seeking from your employer? (e.g., letter of apology from your employer, wages owed, compensatory time, etc.)		

7. Please provide us with any additional information that would be helpful in resolving this issue.

**Please provide any relevant documents along with this form (i.e., your pay stub, employment contract, collective bargaining agreement, employer's policy on sick leave, and copy of your request for sick leave). DCA does not need health-related information to process your complaint. If you do provide any health information, DCA will treat it as confidential and will not disclose it without your permission or unless required by law.**

I affirm that to the best of my knowledge, this information is true, correct, and complete.

_____ Signature of employee filing complaint	_____ Date
_____ Print Name	
_____ Signature of Parent or Guardian (if employee filing complaint is under 18 years of age)	_____ Print name of Parent or Guardian