Department of Consumer Affairs

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, 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 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.

How do you want DCA to help? ☐ Help me resolve my complaint with my employer. ☐ 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.						
YOUR CONTACT INFORMATION						
First Name ☐ Mr. ☐ 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.						
EMPLOYMENT INFORMATION						
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? ☐ Yes ☐ 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:	☐ 1- 4 Employees	☐ 5-19 Employees	☐ 20-99 Employees	☐ 100-499 Employees	☐ 500+ Employees	
Industry: ☐ Education	☐ Government	☐ Health Care	☐ Hospitality/Hotels	☐ Industrial/Manufacturing	☐ Nonprofit	
☐ Professional Services	☐ Restaurant/Food Service	☐ Retail	☐ Grocery	☐ Construction	☐ 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)			☐ Yes	☐ No		
4. Are you still working for your employer?			☐ Yes	☐ No		
5. If you are *not* still working for your employer, please select the reason.			☐ Resigned/Quit	☐ Discharged/Fired	☐ Laid Off	
6. If you are *not* 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?			☐ Yes	☐ No
2. Are you a government employee?			☐ Yes	☐ No
3. Are you part of a federal college work study program?			☐ Yes	☐ No
4. Are you a physical therapist, occupational therapist, speech language pathologist, or audiologist licensed by the New York State Department of Education?			☐ Yes	☐ No
5. Are you part of a Work Experience Program (WEP)?			☐ Yes	☐ No
6. Are you paid as a part of a scholarship program?			☐ Yes	☐ No
7. Are you an independent contractor?	☐ Yes	☐ No	☐ I don't know	
8. Are you a domestic worker?	☐ Yes	☐ No	☐ I don't know	

COMPLAINT INFORMATION			
1. Do you think your employer has violated New York City's Paid Sick Leave Law?		☐ Yes	☐ 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.			
☐ Not allowing me to use sick leave	☐ Not compensating me correctly for sick leave	☐ Not allowing me to carry over sick leave from one year to the next	
☐ Requiring me to find a replacement worker	☐ Requiring me to make up hours missed	☐ Requiring me to provide medical documentation	
☐ Retaliating against me for requesting sick leave, using sick leave, or filing a complaint	☐ Not providing me with the Notice of Employee Rights	☐ 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?		☐ Yes	☐ 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 Print name of Parent or Guardian
(if employee filing complaint is under 18 years of age)