



FILE YOUR COMPLAINT (SICK LEAVE)

Thank you for contacting the New York City Department of Consumer Affairs (DCA). Please complete this form to the best of your ability. 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 questions about this form, please contact DCA at PaidSickLeave@dca.nyc.gov or call 311 and ask for "Sick Leave Complaint."

Submit your complaint in ONE of the following ways:

- Email PaidSickLeave@dca.nyc.gov OR
- Mail to: New York City Department of Consumer Affairs, Attn: Paid Sick Leave Division, 42 Broadway, New York, NY, 10004

HOW DO YOU WANT DCA TO HELP?

Check ONE box only.

- I want DCA's help resolving the complaint with my employer.
- I want DCA to investigate my employer but want to remain anonymous.

Other, including if you are providing a tip to DCA about an employer (Please explain.):

YOUR CONTACT INFORMATION

			Date
First Name	Middle Name <i>(optional)</i>	Last Name	
Address <i>(Building Number, Street Name, Apartment/Suite/Other)</i>			
City	State	ZIP Code	Borough
Phone 1 (Primary)	Phone 2 (Alternate)	Email	
Do you need language interpretation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please specify language:	

EMPLOYER INFORMATION

1. Please list the name and address of your employer:

Employer Name			
Employer Address <i>(Building Number, Street Name, Apartment/Suite/Other)</i>			
City	State	ZIP Code	Borough
Email			

2. Approximately how many people work for your employer? _____
3. Which of the following best describes your employer? Check ONE box only.
 - Public (Government)
 - Nonprofit
 - Private for-profit
 - Other; please describe: _____
4. Which of the following best describes your employer's industry? Check ONE box only.

<ul style="list-style-type: none"> <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 	<ul style="list-style-type: none"> <input type="checkbox"/> Professional Services <input type="checkbox"/> Restaurant/Food Service <input type="checkbox"/> Retail <input type="checkbox"/> Other; please describe: _____
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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).

EMPLOYMENT WITHIN NEW YORK CITY

1. Do you perform work in New York City (Bronx, Brooklyn, Manhattan, Queens, Staten Island)? Yes No
2. Is your employer located in New York City? Yes No
3. Do you perform work in New York City even if your employer is located outside New York City? Yes No

If you do not work within New York City, you are not covered by New York City's Paid Sick Leave Law.

TYPE OF EMPLOYMENT

1. Are you a government employee? Yes No
2. Are you part of a federal college work study program? Yes No
3. Are you an hourly professional employee licensed by the New York State Department of Education under the direction of the New York State Board of Regents (physical therapist, occupational therapist, speech language pathologist, audiologist only)? Yes No
4. Are you part of a Work Experience Program? Yes No
5. Are you paid as part of a scholarship program? Yes No

If you answered Yes to any of these five questions, you are not covered by New York City's Paid Sick Leave Law.

INDEPENDENT CONTRACTORS

New York City's Paid Sick Leave Law applies to employees. Please answer these 13 questions to help us determine whether you are an employee or an independent contractor. No one factor is determinative.

1. Do you have an established business? Yes No
2. Do you advertise in electronic and/or print media? Yes No

- 3. Do you buy ads in the Yellow Pages? Yes No
- 4. Do you use business cards, stationery, and billheads (receipts)? Yes No
- 5. Do you carry insurance? Yes No
- 6. Do you keep a place of business and invest in facilities, equipment, and supplies? Yes No
- 7. Do you pay your own expenses? Yes No
- 8. Do you assume risk for profit or loss? Yes No
- 9. Do you set your own schedule? Yes No
- 10. Do you set or negotiate your own pay rate? Yes No
- 11. Do you offer services to other businesses (competitive or non-competitive)? Yes No
- 12. Are you free to refuse work offers? Yes No
- 13. Are you free to hire help? Yes No

COLLECTIVE BARGAINING AGREEMENTS

- 1. Are you covered by a collective bargaining agreement? Yes No

If you are *not* covered by a collective bargaining agreement, please skip to the section EMPLOYMENT INFORMATION.

- 2. On what date does your collective bargaining agreement end?

/ / (MM/DD/YYYY)

- 3. Do you work in the construction industry or grocery industry? Yes No
- 4. Are you part of a union? Yes No

If you answered Yes, please provide the following:

Name of Your Union
Name of Your Union Representative
Union Contact Information
<input type="checkbox"/> Copy of your collective bargaining agreement

- 5. Do you give DCA permission to contact your union representative? Yes No

EMPLOYMENT INFORMATION

1.	On what date did you start working for your employer? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (MM/DD/YYYY)	
2.	Are you still working for your employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you had any break in employment since the date you started working for this employer? If Yes, please provide dates of break in service.	<input type="checkbox"/> Yes <input type="checkbox"/> No

	If you are <i>not</i> still working for your employer, why not?	
	If you are <i>not</i> still working for your employer, on what date did you stop working? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (MM/DD/YYYY)	
4.	On average, how many hours a week do you work for this employer?	<input type="checkbox"/> 1-15 <input type="checkbox"/> 15-35 <input type="checkbox"/> 35 or more
5.	Your employer should provide you with the Notice of Employee Rights created by DCA. Did your employer provide you with this required notice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If your employer provided you with the required notice, on what date were you given the notice? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (MM/DD/YYYY)	
	Does the notice indicate your employer's calendar year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	What is your employer's calendar year? Start of Calendar Year: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> (MM/DD) End of Calendar Year: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> (MM/DD)	
6.	How many hours have you worked for this employer during the calendar year stated in your notice?	
7.	Are you paid regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, what is your pay date?	
	How often are you paid?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Other
8.	Do you receive a pay stub? If Yes, please provide a copy of a pay stub.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you paid by the hour?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	What is your pay rate?	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly
11.	How much are you paid?	

YOUR COMPLAINT

1.	Do you think your employer has violated New York City's Paid Sick Leave Law? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered Yes, please describe what happened. Use additional sheets, if necessary.	<input type="checkbox"/> Yes <input type="checkbox"/> No														
2.	Have you tried to resolve your complaint with your employer? If you answered Yes, what happened? Use additional sheets, if necessary.	<input type="checkbox"/> Yes <input type="checkbox"/> No														
3.	On what date do you believe your employer violated the law? <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (MM/DD/YYYY)															
4.	Does your employer have a leave policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
5.	<table border="1"> <tr> <td data-bbox="170 1423 711 1465"> Has your employer refused to allow you to take sick leave? </td> <td data-bbox="711 1423 1247 1465"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td data-bbox="170 1465 711 1528"> How much time off did you request? </td> <td data-bbox="711 1465 1247 1528"></td> </tr> <tr> <td data-bbox="170 1528 711 1633"> Was the time requested for yourself or to care for a family member? </td> <td data-bbox="711 1528 1247 1633"> <input type="checkbox"/> For self <input type="checkbox"/> For family member </td> </tr> <tr> <td data-bbox="170 1633 711 1696"> Did you ask for sick leave in writing? </td> <td data-bbox="711 1633 1247 1696"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td data-bbox="170 1696 711 1759"> Did you ask for sick leave by calling? </td> <td data-bbox="711 1696 1247 1759"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td data-bbox="170 1759 711 1843"> Was the time off you requested <i>paid</i> sick leave? </td> <td data-bbox="711 1759 1247 1843"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td data-bbox="170 1843 711 1900"> Was the time off you requested <i>unpaid</i> sick leave? </td> <td data-bbox="711 1843 1247 1900"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>	Has your employer refused to allow you to take sick leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much time off did you request?		Was the time requested for yourself or to care for a family member?	<input type="checkbox"/> For self <input type="checkbox"/> For family member	Did you ask for sick leave in writing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you ask for sick leave by calling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the time off you requested <i>paid</i> sick leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the time off you requested <i>unpaid</i> sick leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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6.	Has your employer refused to pay you for time you were out sick?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many hours of sick leave did you use?		
	When did you use sick leave?		
	Did you ask for sick leave in writing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Did you ask for sick leave by calling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Did you take sick leave even though your employer told you that you could not?		

HAS YOUR EMPLOYER RETALIATED AGAINST YOU?

1.	Has your employer taken any action against you for requesting sick leave, using sick leave, or filing a complaint?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Did your employer cut or reduce your pay?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Has your employer fired you or threatened to fire you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Has your employer demoted you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Has your employer cut your hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Please describe any adverse action your employer has taken against you.		

Please provide any further information you believe will help us understand your complaint:

Please provide any documents, for example, Notice of Employee Rights, pay stub, employer’s policy on sick leave, copy of request for sick leave, or note from medical provider.

I affirm that to the best of my knowledge, this complaint 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