



INTAKE FORM – SAFE AND 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) 436-0380 or (212) 436-0381, or visit DCA at the address below. If you prefer to use a language other than English, we can provide free interpretation assistance. You can submit the completed form in the following ways:

- Email: PSSL@dca.nyc.gov OR
Mail or hand deliver to: New York City Department of Consumer Affairs, Attn: Office of Labor Policy & Standards, 42 Broadway, 9th 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, M.I., Last Name, Primary Language Used, Address, 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, City, State, ZIP Code, Borough, Employer Still in Business?, 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?
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)
4. Are you still working for your employer?
5. If you are not still working for your employer, please select the reason.
6. If you are not still working for your employer, what was your last day of work?

**PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US DETERMINE IF YOU ARE COVERED BY NEW YORK CITY'S EARNED SAFE AND SICK TIME ACT (PAID SAFE AND 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 Safe and 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 Safe and Sick Leave Law. Check all that apply.

<input type="checkbox"/> Not allowing me to use safe or sick leave	<input type="checkbox"/> Not compensating me correctly for safe and sick leave	<input type="checkbox"/> Not allowing me to carry over safe and 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 documentation for safe or sick leave lasting less than three consecutive workdays
<input type="checkbox"/> Retaliating against me for requesting safe or sick leave, using safe or 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 safe and sick leave, and copy of your request for safe or sick leave). DCA does not need information about your health or reason for safe leave to process your complaint. If you do provide any information about your health or reason for safe leave, 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