

**Maryland Earned Sick and Safe Leave Complaint Form**



For Office Use Only: Complaint #

**SECTION I. Employee Information (*Note: Please print or type all information.)***

Name:  First Middle Initial Last

SSN/ITIN *(last four digits)*:  Date of Birth (mo./day/year): 

Address: 

 Street City State Zip Code

*\*If you change your address or telephone number after submitting this form, please notify Employment Standards Service (ESS) immediately* ***in writing****. If ESS cannot contact you, your claim will be dismissed.*

Daytime Telephone:  Email Address: 

Date you were hired:  Your last day worked: 

Job title / Function:  Start date:  End date: 

**SECTION II. Employer Information**

Employer Name: 

Is employer still in business? [ ]  Yes [ ]  No Number of employees [ ]  1-14 [ ]  15 or more

 (including full time, part time, temporary and seasonal)

Employer’s Address:  Street City State Zip Code

Corporation name, if any: 

Employer Contact: 

Telephone: 

Email: 

Direct supervisor’s name: 

Phone: 

Email: 

Please list any other addresses affiliated with the employer:

  Street City State Zip Code

**SECTION III. Employment Information**

1. Do you regularly work more than 12 hours in a week? [ ]  Yes [ ]  No
2. Are you employed in the construction industry? [ ]  Yes [ ]  No If Yes, are you covered by a collective bargaining agreement? [ ]  Yes [ ]  No
3. Do you work on an as needed basis in the health & human service industry? [ ]  Yes [ ]  No
4. Are you an independent contractor? [ ]  Yes [ ]  No
5. Are you employed by a temporary service agency? [ ]  Yes [ ]  No
6. Employment status with this employer. [ ]  Still Employed [ ]  Resigned [ ]  Discharged

(If discharged, state reason): 

1. What type of work do you perform? (For example: carpentry, data entry, nursing): 
2. List primary duties and responsibilities:



1. Address, city, state and zip where work was performed: 
2. In what county/city was, your work performed? 
3. Rate of pay: $  per 

How often were you paid? [ ]  Weekly [ ]  Bi-weekly [ ]  Monthly [ ]  Semi-monthly [ ]  Other (explain)



1. Do you have a copy of your employer’s earned sick and safe leave policy? [ ]  Yes [ ]  No

If yes, please provide.

1. Do you have records of the amount of earned sick and safe leave that is available for your use? [ ]  Yes [ ]  No

If yes, please provide including recent paystubs.

1. Date(s) earned sick and safe leave violation(s) occurred: 
2. Total number of hours of earned sick and safe leave that you are claiming. 
3. How you believe earned sick and safe leave violation(s) occurred? (Check all that you allege.)

[ ]  Not allowing me to use earned sick and safe leave [ ]  Not compensating me correctly for earned sick and safe leave

[ ]  Not allowing me to carry over earned sick and safe [ ]  Requiring me to find a replacement worker

 leave from one year to the next

[ ]  Requiring me to make up hours missed [ ]  Requiring me to provide medical documentation

[ ]  Not providing me with the Notice of Employee Rights [ ]  Not providing earned sick and safe leave

[ ]  Retaliating against me for requesting earned sick and safe

 leave, using sick leave, or filing a complaint statement ­[ ]  Other

**SECTION IV. Complaint Details & Statement of Fact**

1. In the space below, please provide all details and information, including dates, witnesses, and location(s) regarding the alleged violation(s). Please be as specific as possible and attach supporting documents and/or additional sheets if needed.



1. Are any of the matters listed above pending in state or federal court? [ ]  Yes [ ]  No
2. If you have retained an attorney to assist you in your complaint alleging a violation or other matter against your employer, please specify name, address, email and phone number(s) of attorney.

**V. Certification and Signature**

I HEREBY CERTIFY that the statements herein, including any attachments, are true and accurate to the best of my knowledge. I UNDERSTAND that acceptance of this complaint by the Maryland Division of Labor and Industry does not guarantee relief. I AUTHORIZE the Division of Labor and Industry to receive any monies paid and mail such monies to me at my own risk.

Employee Signature:  Date: 

Employee Name (printed): 

To the extent practicable, the Commissioner will keep your identity confidential unless you waive confidentiality by checking this box [ ]

You may mail or email your complaint to:

Department of Labor

Division of Labor and Industry
Employment Standards Service
10946 Golden West Drive – Suite 160

Hunt Valley, MD  21031
Telephone Number: (410) 767-2357

E-mail: DLDLIMdLaborComplaint-dllr@Maryland.gov

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