Maryland
DEPARTMENT OF LABOR

Maryland Earned Sick and Safe Leave Complaint Form

Maryland Division of Labor and Industry

For Office Use Only: Reference _____ Complaint # _____

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

Name: _____
First Middle Initial Last

SSN/ITIN *(last four digits)*: _____

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: _____

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):

7. What type of work do you perform? (For example: carpentry, data entry, nursing):

8. List primary duties and responsibilities:

9. Address, city, state and zip where work was performed:

10. In what county/city was your work performed?:

11. Rate of pay: $ per

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

12. Do you have a copy of your employer's earned sick and safe leave policy? ☐ Yes ☐ No
    If Yes, please provide.

13. 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.

14. Date earned sick and safe leave violation occurred?

15. Total number of hours of earned sick and safe leave that you are claiming.

16. How you believe an earned sick and safe leave violation occurred?

- ☐ 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 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
- ☐ 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 details, including dates, regarding the alleged violation. Please be as specific as possible and attach additional sheets if needed.

In the space below, please identify what harm you feel you have suffered as a consequence of the alleged violation. Be specific and include the date(s) and location(s) in which the alleged violations occurred. Attach additional sheets if needed.

Specific Harm	**Date(s)**	**Location(s)**

2. Are any of the matters listed above pending in state or federal court? ☐ Yes ☐ No

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 ☐