EPST/Minimum Wage Retaliation Claim Form

INDUSTRIAL COMMISSION OF ARIZONA LABOR DEPARTMENT P.O. BOX 19070 PHOENIX, ARIZONA 85005-9070 PHONE (602) 542-4515 FAX 602-542-8097

RET	\LIA	TION
------------	-------------	------

Case No.

(FOR OFFICE USE ONLY)

CT 1 T 5 1 T T T T T T T T T T T T T T T					
CLAIMANT INFORMAT		<u>.</u>			linon
*Last Name:	*First 1	Name:		MI:	*DOB:
*Address (including Apa	artment No, if applicable	e):	E-M	Iail Address:	
*City:	*State:	*Zip Code:	*Telephone Number	: Cell Phone	e Number:
DETERMINES THAT YO ONLY BE DISCLOSED	OUR NAME MUST BE D WITH YOUR CONSENT on that requires your emplor or employer to retaliate aga confidentiality and <u>I AGF</u>	ISCLOSED I If you do not be to compenie to compenie to for for forms in the compenies of t	N ORDER TO INVES' of agree to the release of insate you for amounts filing this Retaliation C	TIGATE YOUR of your name, the that you may be laim.	THE LABOR DEPARTMENT CLAIM, YOUR NAME WILL to Labor Department will not be owed. Pursuant to A.R.S. § 23-et to my employer if
☐ I understand my right to confidentiality and <u>DO NOT</u> want my name released to my employer. I understand that the Labor Department will not be able to issue a determination that requires my employer to compensate me for amounts that may be owed.					
*Select ONE preferred m Note: You must promptly					
EMPLOYER INFORMA	TION:				
*Employer Name (as indic	cated on a paystub or tax form	1):	Supervisor:	*Telephon	e Number:
*Address (including Suit	te No., if applicable):	<u>, </u>			
*City:	*State:		*Zip Code: Ow	ner's Name(s):	
Owner's Mailing or E-M	fail Address (if available):		L L		
Additional Information (t	business e-mail address, corpo	orate name, ado	litional business addresse	s, owner's cell pho	one number, etc.):
EMPLOYMENT INFOR	MATION:				
*Your Job Title:		Type	of Work Performed:		
Address Where Work W	as Performed:				
*Start Date of Employme	ent:	*	Last Date of Employ	ment:	
*Rate of Pay: \$ \square Ho	ourly Commission	Other			
How Often Were You Paid: □ Weekly □ Bi-Weekly □ Semi-Monthly □ Monthly					
COMPLAINT INFORMA					
*What type of retaliation ☐ Demotion ☐ Reduction			*		
*Why did the retaliation					
*When did the retaliation					
Name(s) of person(s) who witnessed the retaliation or discrimination:					
*What is the dollar amount you lost due to the retaliation or discrimination?					
How did you arrive at the amount?					
(Please use Page 2 expand on your answers, if necessary)					

Retaliation Claim Form

"Provide a <u>detailed</u>	<u>i</u> statement of the events, actions an	a discrimination and/or	retanation that occurred:
NOTE: SUBMITTING	G AN INCOMPLETE RETALIATION CI	LAIM FORM MAY DELA	Y OR RESULT IN DISMISSAL OF YOUR CLAIM.
harabre cartific that th	signing a true atatament to the heat of my line	arriadae and further cortific	that the above listed information is complete and accurate
l mereby certify that it	ins is a true statement to the best of my kind intended of this Retaliation Claim by the La	shor Department does not a	that the above-listed information is complete and accurate. uarantee an award or collections of an award. I authorize
the Lahor Denartment	to receive monies due to me and to mail si	ich monies at my own risk	(Checks may be picked up or will be mailed to the address
on file at the Labor De		den momes at my own risk.	(Cheeks may be picked up of will be maned to the address
Inc at the Eurof Di			
*I have supporting	documents and evidence related	to my Retaliation Clair	m. \(\text{Yes} \) \(\text{In No.} \) If "Yes," you must promptly
			t by U.S. Mail (P.O. Box 19070, Phoenix, AZ
			i by O.S. Maii (F.O. Box 19070, Filoellix, AZ
83003-90/0), Fax	(602-542-8097), or e-mail (Labori	ınv@azıca.gov).	
*Date:	*Claimant's Name:		/
		Print	Signature