



# Living Wage Ordinance Employee Complaint Form

Date: \_\_\_\_\_

Your Name: \_\_\_\_\_

Your Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of the Company/Organization you work for: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County Department contracting these services \_\_\_\_\_

Describe services provided to the County: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Complaint relates to: (check all that apply)

Wages  Health Benefits  Retaliation

Describe your complaint:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Please attach additional pages (if necessary) and any related documents or evidence; such as, pay stubs, timesheets, etc.)

Certification: To the best of my knowledge, the information provided in this complaint is true.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Do not write in this space	
Complaint Number _____	Assigned to: _____
Notes _____	
_____	