

# WE ARE YOUR DOL



## Warehouse Worker Complaint Form

### 1. Are you an employee of a Warehouse Distribution Center?

This includes establishments for warehousing and storage, merchant wholesalers, electronic shopping and mail-order houses, and couriers and express delivery services. *Excluding farm product warehousing and storage.*

Yes                  No

### 2a. Are there 100 or more employees working at your location?

Yes                  No

### 2b. If No, does your employer operate more than one warehouse location in New York State with a total of 1000 or more employees?

Yes                  No

*If you answered "Yes" to either question 2a or 2b, please continue to fill out this form.*

*If you answered "No" to both questions, your employer would not meet the criteria to be within our jurisdiction. Thank you.*

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### 3. Claimant Information

Claimant First and Last Name:

Claimant Mailing Address:

Claimant Phone Number:

Claimant E-Mail Address:

Description of Job Duties:

Rate of Pay:

Per:

Date of Hire:

Union Membership:                  Yes                  No

If Yes, Union Name/Local #:

**4. Business Information:**

Name of Business:

Address of Business (Including County):

Work Location (If not the same as business headquarters):

Business Phone Number:

Business Contact Person:

Business Owner's Name:

Business Owner's Phone Number:

Business Owner's E-Mail Address:

**5. Complaint Details**

Has your employer imposed a quota on your work output?                      Yes                      No

If yes,

Has your employer provided the quota criteria in writing?                      Yes                      No

**6. Has your employer taken an adverse action or retaliated against you for:**

*(Reduced pay/hours, termination)*

a) Not meeting the quota?                      Yes                      No

b) Asking about the quota?                      Yes                      No

If Yes to either 6a or 6b, would you like to file a complaint about retaliation?

Yes                      No

If yes, please provide details including a timeline of events/actions that occurred before and after the retaliation occurred:

**Paper Submission:** To file this complaint via mail, please complete and sign this form with black ink and send it to: New York State Department of Labor, Division of Safety and Health, State Office Campus, Building 12, Room 169, Albany, NY 12226.