

CLAIM FOR WAGES

LABOR STANDARDS

1510 E. PERSHING BOULEVARD
WEST WING, ROOM 150
CHEYENNE, WYOMING 82002
Phone: (307) 777-7261
Fax: (307) 777-5633

FOR LABOR STANDARDS USE ONLY	
Claim No.	_____
Date Opened	_____
Date Closed	_____
Reason	_____

(Please print or type, and answer all questions)

CLAIMANT

- Employee (Full Name) _____
- Social Security Number _____ 3. Age _____ 4. Sex _____ 5. Telephone _____
- Address _____ 7. City _____ 8. State _____ 9. Zip Code _____
- Name, Address, Phone Number of person through whom you can always be located:

- Describe the kind of work done for Employer _____

AGAINST

- Employer or Firm _____ Individual _____
Partnership _____
Corporation _____
- Owner(s) Full Name _____
- Employer's Mailing Address _____ City _____ State _____ Zip Code _____
- Employer's Physical Address _____ 16. Telephone _____
- Type of Business _____ 18. City where work was done _____ State _____ Address _____
- Name of person in charge _____ 20. Hired by _____ (a) Date _____
- Quit ___ Discharged ___ Laid Off ___ Date _____ Still employed _____ 22. Have you made a written ___ oral ___ request for your wages?
(a) To whom and on what date? _____ (b) If no request made, please explain _____
- Reason given by employer for failure to pay _____
- Describe the wage agreement: Union _____ Non-union _____ Written _____ Oral _____ (a) If union or written, attach copy.
(b) If oral, were witnesses present? _____
- Describe rate of pay and how paid: Hour _____ Day _____ Week _____ Month _____ Piece rate _____ Commission _____
Independent Bid _____ Other _____ 26. What are the employer's regular scheduled payday(s)? _____
- Has a payday passed since your separation? Yes _____ No _____ (a) If yes, what date? _____
- Do you have any of your employer's property? _____ (a) If yes, what? _____
- Do you owe the employer for any goods or services purchased? _____ (a) If yes, show balance due \$ _____
- Do you owe the employer for any cash advances? _____ (a) If yes, amount owed _____

WAGES CLAIMED

From _____ 20 _____ to _____, 20 _____, being _____
Month/Day Month/Day Number of hours, days, weeks, months

At the rate of \$ _____ Per _____
Hour, day, week, month

_____ Total \$ _____

Less deductions as follows (cash advances, board, room, etc.)..... \$ _____

Do not include any tax deductions _____ Gross amount claimed..... \$ _____

STATEMENT OF FACTS

(Use additional sheet if necessary. Attach copies of documentation to support your claim.)

I HEREBY CERTIFY that this is a true statement of wages due me to the best of my knowledge and belief. I hereby assign to the Deputy Administrator of the Department of Workforce Services, Labor Standards and/or staff and agents the right to receive any unpaid wages obtained as payment on this claim. I hereby authorize the Department of Workforce Services, Labor Standards to approve a proposed compromise adjustment or settlement of this claim unless I object in writing to such proposal within ten days after notification.

Signature _____ Date _____

INCOMPLETE OR UNSIGNED FORMS WILL BE RETURNED FOR CORRECTION
CLAIMANT (EMPLOYEE) RETAINS PINK COPY FOR THEIR RECORDS

