ILLINOIS DEPARTMENT OF LABOR
160 North LaSalle Street, Suite #C-1300
Chicago, Illinois 60601
http://labor.illinois.gov/

PLEASE PRINT OR TYPE ALL INFORMATION
Use additional sheets if necessary. Attach copies of all supporting documentation and other evidence.

Print Form

FOR OFFICE USE ONLY: Claim Number Received

EQUAL PAY COMPLAINT FORM

I. EMPLOYEE INFORMATION:

Last name: _____ First name: _____ Initial: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone number: _____ Work phone number: _____

Date you were hired: _____ Your last day worked: _____

Your job title with employer: _____ Start date in title: _____ End date in title: _____

II. EMPLOYER INFORMATION:

Employer Name: _____ Is this employer still in business? ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip code: _____

Corporation name, if any: _____ Number of employees: _____

Employer contact name: _____ Contact phone number: _____

Name of your direct supervisor: _____ Industry of employer: _____

III. EMPLOYMENT INFORMATION:

1. Did you sign an employment contract or agreement? ☐ Yes (if yes, attach a copy) ☐ No 2. Were you an independent contractor? ☐ Yes ☐ No
3. Employment status with this employer? ☐ Quit ☐ Discharged If discharged, state reason: _____ ☐ Still employed by
4. Do you supervise anyone? ☐ Yes ☐ No
5. Did your job require a college degree, formal education, or training? ☐ Yes ☐ No If yes, specify: _____
6. What type of work did you perform? (For example; carpentry, data entry, nursing) _____
7. List primary duties and responsibilities:
   A. _____ C. _____
   B. _____ D. _____
8. Address, city, state and zip where work was performed? _____
9. In what county was your work performed? _____ 10. Rate of pay: $ _____ per _____
11. How often were you paid?: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Other (explain:) _____
12. Other type of compensation (Check all that apply):
   ☐ Vacation Pay ☐ Sick Leave ☐ Holiday Pay ☐ Overtime Pay ☐ Health/Life Insurance ☐ Commissions
   ☐ Pension/401K ☐ Profit Sharing ☐ Bonus ☐ Other (describe:) _____

IV. COMPLAINT DETAILS & STATEMENT OF FACT:

13. Date of the underpayment: _____
14. In the space provided below, please state the facts concerning the alleged violation. Please be as specific as possible. Attach additional sheets if needed.

_____

_____

_____

_____

15. In the space provided below, please identify each specific harm you have suffered as a consequence of the alleged violation, including the date(s) and place(s) in which the alleged violations occurred. Attach additional sheets if necessary.

Specific Harm	Date(s)	Place(s)

16. Are any of the matters listed above pending in State or Federal court?
☐ Yes ☐ No If yes, explain: _____
17. Please provide the name and telephone number of someone who will know how to reach you:
Last name: _____ First name: _____ Phone number: _____ Relationship to Employee: _____

V. CERTIFICATION & SIGNATURE:

I HEREBY CERTIFY that the statements herein, including attachments, are true and accurate to the best of my knowledge and belief. I UNDERSTAND that acceptance of this complaint by the Illinois Department of Labor does not guarantee collection. I AUTHORIZE the Department of Labor to receive any monies paid and to mail such monies to me at my own risk.

Date: _____ Employee Signature: _____