

# WE ARE YOUR DOL



## Mandatory Overtime for Nurses Complaint Form

\* Indicates required fields

**Are you an RN or LPN, or do you represent an RN or LPN?\***    Yes    No

(If 'No', please do not complete this form.)

**Do you work, or have you worked, in a covered healthcare facility and were mandated to work overtime?\*** (Examples of covered facilities include hospitals, nursing homes, residential health care facilities, facilities operated or licensed by the Office of Child and Family Services, etc.)    Yes    No

(If 'No', please do not complete this form.)

### Claimant Information

First Name\*:  Last Name\*:

Your mailing address

Street:

City/Town:  County:  State:  Zip Code:

Your Phone Number\*: ()  -  Your Email:

Job Title/Description of your Job Duties\*:

Are you an hourly employee?    Yes    No

Union Membership?    Yes    No

If 'Yes', Local name and number:

### Business Information

Name of Business\*:

Address of Business (including county)

Street\*:

City/Town\*:  County\*:  State\*:  Zip Code:

Is the Work Location same as Address of Business?\*    Yes    No

Street\*:

City/Town\*:  County\*:  State\*:  Zip Code:

Name of Supervisor: \_\_\_\_\_ Supervisor's Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Nature of employer's business\*:    Hospital    Nursing Home    OCFS facility    Other - Explain

### Complaint Details

For each incident for which you had to work mandatory overtime, provide the date, the hours you were originally scheduled to work, and the overtime hours you were required to work.\*

| Date(s)              |                      |                      | Original Schedule    |                      |                      | Mandatory Overtime   |                      |                      |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| MM/DD/YYYY           | Start Time           | End Time             | Total Hrs.           | Start Time           | End Time             | Total Hrs.           |                      |                      |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
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| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Did your employer explain the reason for the mandatory overtime?    Yes    No

If "Yes," what reason was given?

If "Yes," what were the circumstances?

Was the overtime required during any declared national, state, or municipal emergency or disaster or other catastrophic event\*?    Yes    No    Not Sure

If yes, please explain:

If yes, do you know if the employer is reporting their use of mandatory overtime during an emergency to the DOH and DOL?    Yes    No    Not Sure

Was the overtime required because your employer determined there was a patient care emergency?

Yes    No    Not Sure

If "Yes," please explain:

Depending on the reason for the mandatory overtime, your employer may have been required to exhaust reasonable efforts to obtain staffing. Please answer the following questions to the best of your knowledge:

- a. Did your employer ask for volunteers to work overtime?    Yes    No    Not Sure
- b. Did your employer contact employees who made themselves available to work extra time?  
Yes    No    Not Sure
- c. Did your employer contact per diem staff?    Yes    No    Not Sure
- d. Did your employer contact a temporary agency?    Yes    No    Not Sure

Does your employer have a Nurse Coverage Plan?    Yes    No

Does your employer display the required poster? <https://dol.ny.gov/restricted-nurse-hours-poster>

Yes    No

Are you a union representative filing this complaint on behalf of your members?\*    Yes    No

Please use the space below to provide any additional information you may have regarding this complaint.