

Warehouse Worker Complaint Form

Please Download to Fill Out and Submit 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.

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 Day Week Bi-Week Year

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, 1220 Washington Ave., Building 12, Room 169, Albany, NY 12226.

Upon completing this form, save it to your computer. Click the link provided (labor.sm.warehouse.worker.claims@labor.ny.gov) to open your email application. Attach the saved form and send.