

NJ Dept. of Labor & Workforce Development
 Division of Wage & Hour Compliance
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OFFICIAL USE ONLY:

Claim# _____ Empl # _____
 Field ___ IBM ___ WC ___ No Jurisdiction ___
 Field Rpt# _____
 Case# _____

MANDATORY OVERTIME COMPLAINT FORM

File a Mandatory Overtime Complaint if you are a health care worker who provides direct patient care (e.g. nurse, nursing assistant, home health aide, etc., but not a doctor) and you believe your New Jersey employer improperly required you to work overtime.

Instructions: You may file your complaint online or by mail.

To file online visit www.nj.gov/labor. Click on Worker Protections, then Wage & Hour Compliance, and then File a Wage Claim.

To file by mail, complete both sides of this form and answer all questions. Type or print legibly. Attach any documents that support your claim. Mail or fax all documents to the address listed at the top of this form.

1. First Name _____	Last Name _____	M.I. _____	3. Phone No. () _____
2. Mailing Address _____	Floor / Apt. No. _____		4. Alternate Phone No. () _____
City _____	State _____	Zip Code _____	5. Social Security No. <i>(If you prefer, leave blank)</i> _____
6. Are you involved in direct patient care activities or clinical services? <input type="checkbox"/> Yes <input type="checkbox"/> No Briefly describe your job duties: _____			Occupation and Job Title: _____
7. Are you an hourly employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is your hourly rate of pay? \$ _____ per hour			
8. Name of Employer _____			
9. Employer Street Address <i>(not a PO Box)</i> _____			
City _____	State _____	Zip Code _____	County _____ Employer Phone No. _____
10. Employer Mailing Address <i>(if different from street address)</i> _____			
11. Nature of Employer's Business: _____			

MANDATORY OVERTIME INFORMATION

12. 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		
	Start Time	End Time	Total Hrs.	Start Time	End Time	Total Hrs.
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

13. Did you volunteer to work overtime or did you agree to be on-call? Yes No
 If yes, please explain (attach additional sheets if necessary): _____

14. Were you participating in a surgical or therapeutic interventional procedure during which it would have been detrimental to the patient if you had left? Yes No
 If yes, please explain (attach additional sheets if necessary): _____

15.	Did your employer explain the reason for the mandatory overtime? If yes, what reason was given?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
16.	Was the overtime required due to an unforeseeable circumstance? If yes, what were the circumstances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
17.	Do you believe the overtime was required due to vacancies resulting from chronic staffing shortages? If yes, please explain and attach any supporting documentation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
18.	Was the overtime required due to any declared national, State, or municipal emergency or disaster or other catastrophic event? If yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
19.	Was the overtime required because your employer activated its emergency or disaster plan? If yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
20.	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
	b. Did your employer contact employees who made themselves available to work extra time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
	c. Did your employer contact per diem staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
	d. Did your employer contact a temporary agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
	e. Did your employer provide you with any documentation which demonstrates their efforts to obtain staffing? If yes, attach a copy of the documentation to this form.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
21.	Prior to working the required overtime, did your employer provide you with the necessary time, up to a maximum of one hour, to arrange for the care of your minor children or elderly or disabled family members? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
	If no: List the individuals (include ages of minor children) who required care arrangements: How much time did your employer give you to make care arrangements? How much time did you need to make the arrangements?			
22.	Please use this space to provide any additional information you may have regarding this complaint. Attach any documentation you may have that supports your complaint.			
23.	I understand that the employer has the right, under the Open Public Records Act (OPRA), to request all information on this claim however, we will endeavor to protect the identity of a complainant or witness to the maxim extent allowable by law. <i>(If you are filing anonymously, you are not required to sign below.)</i>			
	Signature _____		Date _____	