

EMPLOYMENT COMPLAINT FORM

Mail To:
 KENTUCKY LABOR CABINET
 DIVISION OF WAGES AND HOURS
 500 MERO STREET, 3RD FLOOR
 FRANKFORT KY 40601-4220
 Telephone: 502-564-3534 ~ Fax: 502-696-1897
 www.labor.ky.gov

Personal Information		
Full Name:	Hourly/Salary Wage:	
Home Address:	Amount Owed:	
City, State, & Zip Code:	Email Address:	
Social Security Number:	Cell Number:	
	Home Phone Number:	
Nature of Complaint:		
I authorize the KY Labor Cabinet to use my name in this investigation.		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____ Signature: _____
Business Information		
Business Name:		
Employer's Contact Person:	Contact Person's Title:	
Employer's Kentucky Address:		Phone:
City:	County:	Zip:
If Home Office is Out of State, Give Address:		
Period of Employment From:	To:	
Give your job title and describe your duties:		
DO NOT WRITE IN THE SECTION BELOW:		
Case Number:		
Assigned to:		
Date Assigned:		
Type of Complaint:		
Assigned by:		

DO NOT WRITE ON THE BACK OF THIS FORM - ATTACH ADDITIONAL SHEETS IF NEEDED