

PROHIBITION OF EXCESSIVE OVERTIME IN HEALTH CARE COMPLAINT FORM

Instructions: Review and complete both pages of complaint form. All submissions must be signed and dated. Additional information may be submitted on a separate 8-1/2" x 11" sheet of paper and if applicable include all supporting documents. Submit the completed form and all attachments to:

Department of Labor & Industry
Bureau of Labor Law Compliance
651 Boas Street, Room 1301
Harrisburg, PA 17121-0750
Telephone: 800-932-0665
Fax: 717-787-0517

Claimant Information (Print or type all information)

Name of person filing complaint: _____

Address: _____
Street (Apt. #) City State Zip Code

Telephone: () _____ Fax: () _____
Include Area Code Include Area Code

Email address: _____

Occupation and job title: _____

Are you involved in direct patient care or clinical services? Yes No

Are you an hourly employee? Yes No

Do you supervise? Yes No

Briefly describe your job duties: _____

Employer Information (Print or type all information)

Name of employer: _____

Address: _____
Street (Apt. #) City State Zip Code

Telephone: () _____ County: _____
Include Area Code

What type of care does your employer provide? _____

Name of your supervisor or individual who requested that you work overtime: _____

If available, direct telephone extension for supervisor: () _____
Include Area Code

Provide the date, hours originally scheduled to work, and the overtime hours worked for each time you had to work mandatory overtime. *Include additional sheets if necessary.*

| Original Schedule Shift(s) | | | | Mandatory Overtime | | | |
|----------------------------|------------|----------|-------------|--------------------|------------|----------|-------------|
| Date | Start time | End time | Total hours | Date | Start time | End time | Total hours |
| | | | | | | | |
| | | | | | | | |

1. Did you volunteer to work overtime? Yes No
If yes, please attach additional information.
2. Did you agree to be on call? Yes No
If yes, please attach additional information.
3. a) At or before the time overtime was requested, were you participating in any procedure? Yes No
 b) Could your absence have had an adverse effect on the patient? Yes No
If necessary, please attach additional information.
4. Did your employer explain the reason for mandatory overtime? Yes No
If yes, please attach additional information.
5. To your knowledge, was the overtime required due to any of the following?
 - a) Unforeseen circumstance? Yes No Not sure
 - b) Vacancies resulting from chronic staff shortages? Yes No Not sure
 - c) A national, state or municipal emergency or other emergency? Yes No Not sure**If yes for any, please attach additional information.**
6. To your knowledge, did your employer do any of the following:
 - a) Ask for volunteers to work overtime? Yes No Not sure
 - b) Contact per diem staff? Yes No Not sure
 - c) Contact a temporary agency? Yes No Not sure
 - d) Provide you with up to one hour to arrange care for children or disabled family members? Yes No Not sure
 - e) Provide you with any documentation concerning efforts to obtain staffing? **If yes, please attach.** Yes No
7. If you are aware of any potential witnesses the Bureau may contact during this investigation, please provide information here:

| Name | Phone/Contact information | Position |
|------|---------------------------|----------|
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I verify that facts set forth in this complaint are true and correct to the best of my knowledge, information and belief. I sign this complaint subject to 18 Pa.C.S. § 4904 (relating to unsworn falsifications to authorities).

Signature: _____ **Date:** _____

*Auxiliary aids and services are available upon request to individuals with disabilities.
 Equal Opportunity Employer/Program*