pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF LABOR LAW COMPLIANCE

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

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