GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

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DEPARTMENT OF LABOR

#4401 Sion Farm - Christiansted St.
Croix, VI 00820-4245 Telephone:
(340) 773-1994
Email: laborrelations@dol.vi.gov

P. O. Box 302608 - Charlotte Amalie
St. Thomas, VI 00803-2608
Telephone: (340) 776-3700
Email: laborrelations@dol.vi.gov

Division of L*abor Relations*

Wage Claim Form

WC-_____-_____-_____

Complainant Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Mailing Address *City/State/Zip*

_____
Physical Address *City State/Zip*

Home Phone: _____ Email Address: _____

Job Title/ Duties: _____

Employer Contact Information

Company: _____
Name *Authorized Representative*

Address: _____
Mailing Address

_____
City *State* *ZIP Code*

Phone: _____ Fax: _____

Employed From: _____ Employed Until: _____

Estimate of Number of Employees: _____ Branches or Other Locations: _____

Date of Birth if under 21: _____ Company/HR E-mail: _____

Rate of payment: _____ _____

Enter in the boxes below the hours you usually work each day and each week (less time off for meals if applicable):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total

CHECK THE APPROPRIATE BOX(ES):

- ☐ Does not pay the minimum wage
- ☐ Does not pay proper overtime
- ☐ Deductions from wages
- ☐ Failure to pay wages

EXPLAIN BRIEFLY IN THE SPACE BELOW the employment practices which you believe violated the Wage and Hour Laws. (If you need more space use an additional sheet of paper and attach it to this form.)

I hereby affirm that the above charge is true to the best of my knowledge, information and belief.

_____ _____

Signature of Complainant Date