

**STATE OF
NEW HAMPSHIRE
DEPARTMENT OF LABOR**
PO BOX 2076
CONCORD, NH 03302-2076

WAGE CLAIM
Filed under RSA 275:51

Contact Information

Phone (603) 271-6294
(603) 271-1492
(603) 271-3176

E-Mail InspectionDiv@dol.nh.gov

FAX (603) 271-2668

CLAIMANT

Name _____ SSN (optional) _____

Mailing Address _____
(Street) (City/Town) (State) (Zip)

E-Mail Address (optional) _____

Telephone-Home _____ Cell _____ Work _____

EMPLOYER

Establishment name _____ Telephone: _____

Mailing Address _____
(Street) (City/Town) (State) (Zip)

Representative _____ Title _____

Type of business _____ Employer ID # _____

Did you complete a W-4 form? Yes No Unsure

Was your employer a sub-contractor? No Yes If YES, complete section below

Name of Prime Contractor (if applicable) _____ Telephone _____

Address _____
(Street) (City/Town) (State) (Zip)

Employee Leasing Company (if applicable) _____ Telephone _____

Address _____
(Street) (City/Town) (State) (Zip)

CLAIM Describe your claim. Use additional pages if necessary.

TOTAL Amount (required) \$ _____ Type of work _____ Location of work _____

CERTIFICATION

I hereby certify that this is a true statement of the wages owed me by the above employer.

Date _____ Signed _____

ASSIGNMENT

I grant the Labor Commissioner authorization to settle and adjust my claim, for wages and/or any claim for liquidated damages in the event it is deemed such action to be necessary pursuant to RSA 275 as Amended Section 53, par II.

Date _____ Signed _____