MINIMUM WAGE ORDINANCE PAID SICK LEAVE DETERMINATION REQUEST FORM GUIDE

Please use this guide to assist in completing the MW-7 Minimum Wage Ordinance Paid Sick Leave (PSL) Determination Request Form. For any questions regarding this form, contact the Office of Wage Standards (OWS). Submit a completed form with all appropriately labeled ***ATTACHMENTS***, if any, to the OWS at wagesla@lacity.org or 1149 S. Broadway, Suite 300, Los Angeles, CA 90015.

PRELIMINARY NOTICE

If you or the Employer for whom the determination is being requested has a paid leave or paid time off policy or provides payment for compensated time off, that is equal to or no less than 48 hours annually, no additional time is required, according to Los Angeles Municipal Code (LAMC) Section 187.04(F). Please also refer to the PSL section of the Frequently Asked Questions document available on our website (http://wagesla.lacity.org) for more information. If an Employer is in compliance with LAMC Section 187.04(F), that Employer does NOT need to complete the MW-7 Minimum Wage Ordinance PSL Determination Request Form.

SECTION I: GENERAL INFORMATION – ALL APPLICABLE FIELDS ARE REQUIRED

1. **Requesting Group Type:** Check the type of organization that is requesting this determination (i.e., Employer, Attorney, or Other). If you are an attorney or any other group, enter the name of your law firm or group in the space provided.
2. **Employer Name:** Enter the legal name of the Employer or business entity that is the subject of this request.
3. **Industry Type:** Enter the type of industry of the Employer.
    - *EXAMPLE: Retail/Wholesale, Construction, Healthcare, Entertainment.*
4. **EIN:** The Federal Employer Identification Number (EIN) (also known as Federal Tax Identification Number) is a unique and permanent nine-digit number assigned by the Internal Revenue Service used to identify a business entity. The EIN should be notated in a previously filed tax return if one has been filed.
5. **Phone:** Enter the area code and phone number of the Employer. You will enter the phone number of the representative submitting this form later.
6. **Address:** Enter the physical business address of the Employer. Include the number and street name, as well as any floor or apartment number, city, state, and zip code. If the Employer has multiple locations, enter the main location or headquarters.
7. **Contact Name:** Enter the name of the representative (herein referred to as “signing representative”) who is submitting this form and should be contacted for information related to this request.
8. **Mailing Address:** Enter the mailing address of the signing representative, Requesting Group, or Employer. Include the number and street name, as well as any floor or apartment number, city, state, and zip code. The OWS will mail copies of information related to this request to the address entered here.
9. **Contact Phone:** Enter the area code and phone number of the signing representative. The OWS may call this number for information related to this request.
10. **Contact Email:** Enter the email address of the signing representative. The email address entered here may be used to request or send information related to this form.

SECTION II: DETERMINATION CRITERIA

11. **Notification:** If all Employees for whom this determination is requested have been notified of and offered access to a combined paid and/or unpaid sick leave totaling 48 hours per year that can be taken with no adverse action, check yes. If all Employees have not been notified or offered access, check no and provide an explanation. If additional space is necessary, use the space provided in ***ADDITIONAL COMMENTS (#13)*** and/or attach as needed.
12. **Benefit Chart:** Complete the chart with as much information as applicable. If additional columns are required, see ***ATTACHMENT***. An individual column in the chart should be completed for a single group of Employees who receive the same benefits (herein referred to as “Employee Category”). For guidance on the determining criteria to qualify and be considered more generous, please refer to the Minimum Wage Ordinance Rules & Regulations available on our website.
    A. **Trade/Type of Work:** The trade or type of work specific to this Employee Category.
        - *EXAMPLE: Ironworker, Cement Mason, Laborer.*
    B. **Classification Type:** The specific classification of the trade/type of work of the Employee Category.
        - *EXAMPLE: Apprentice, Pre-Apprentice, Journeyman.*

C. **Step:** The step or level of the specific classification of the trade/type of work of the Employee Category.
   - *EXAMPLE: I, II, III, 40%.*

D. **Employment Status:** The classification or status of the Employee Category.
   - *EXAMPLE: Full-Time, Part-Time, Per Diem.*

E. **Compensated Time Off Total Hours and Types Included in This Total:** After *TOTAL HOURS*, enter the total number of hours of compensated time off given and made accessible on an annual basis to this Employee Category. Check all applicable types of compensated time off included in the *TOTAL HOURS* amount. If there is an additional type, check the last option and enter the type(s).

F. **Hourly Wage Rate:** The base wage rate paid to the Employee Category on an hourly basis.

G-I. **Funds (Health & Wellness, Pension, Vacation & Holiday):** The amount in dollars rounded to the nearest cent provided to the Employee Category per hour in the respective fund. If a percentage of the hourly wage is provided for a fund, calculate and enter the hourly amount in dollars rounded to the nearest cent.

J. **Additional Benefits:** Check all additional benefits provided to the Employee Category. If there is an additional benefit not provided, check the last option and describe the benefit.

K-L. **Other:** Describe any additional benefit(s) provided to the Employee Category that you feel should be taken into consideration in your request. Enter the name and value of the benefit, if possible.

13. **Additional Comments:** Enter any supplementary comments here (i.e., additional contact information, explanation). If additional space is required, see ***ATTACHMENT***.

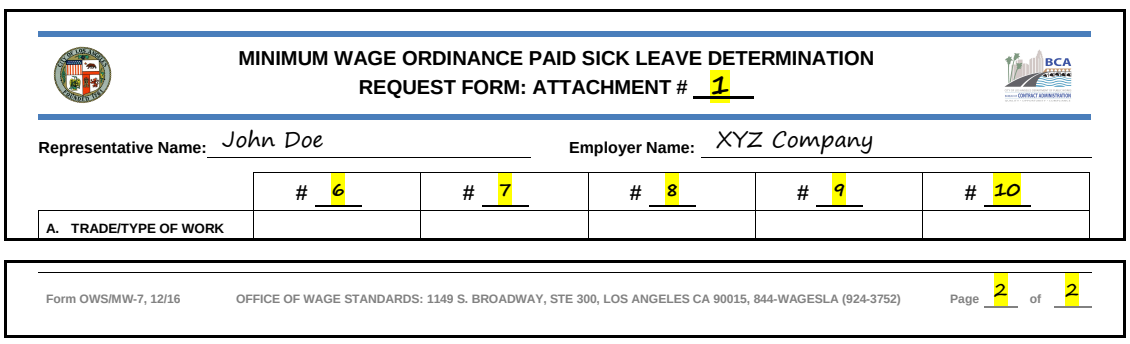
SECTION III: SIGNATURE

By signing, you declare under penalty of perjury under the laws of the State of California that the information provided on the form is true and correct to the best of your knowledge.

- **Print Name:** The name of the signing representative that should be contacted for information related to this request.
- **Title/Affiliation:** The title or affiliation with the Requesting Group of the signing representative.
- **Signature:** The signature of the signing representative.
- **Date:** The date the signing representative signed the form.

ATTACHMENT

- Enter the name of the signing representative and the name of the Employer that is the subject of this request at the top of each attachment page.
- Complete the table and/or the *ADDITIONAL COMMENTS* section as needed. For guidance, see ***BENEFIT CHART (#12)*** *and/or* ***ADDITIONAL COMMENTS (#13)***. If additional columns or space is required, complete additional copies of the ***ATTACHMENT*** page and attach all pages to the request form (Page 1 of the MW-7).
- Complete the *ATTACHMENT NUMBER* at the top of the page, the *PAGE NUMBERS* at the bottom of the page, and the corresponding number of the additional columns in the table accordingly. See below for an example.



MINIMUM WAGE ORDINANCE PAID SICK LEAVE DETERMINATION
REQUEST FORM: ATTACHMENT # 1

Representative Name: John Doe Employer Name: XYZ Company

	# 6	# 7	# 8	# 9	# 10
A. TRADE/TYPE OF WORK					

Form OWS/MW-7, 12/16 OFFICE OF WAGE STANDARDS: 1149 S. BROADWAY, STE 300, LOS ANGELES CA 90015, 844-WAGESLA (924-3752) Page 2 of 2

Print Form

MINIMUM WAGE ORDINANCE PAID SICK LEAVE DETERMINATION REQUEST FORM

The Office of Wage Standards (OWS) has been designated by City Council as the Designated Administrative Agency (DAA) responsible for administering and enforcing the Minimum Wage Ordinance (Los Angeles Municipal Code [LAMC] § 187 et. seq.). LAMC § 187.07 authorizes the OWS to "allow an Employer's established paid leave or paid time off policy or one which provides payment for compensated time off to remain in place and comply with the article even though it does not meet all the requirements in § 187.04, if the DAA determines that the Employer's established policy is overall more generous." Determining criteria to qualify and be considered more generous may include but are not limited to a combination of factors, and each circumstance will require an individual analysis.

PRELIMINARY NOTICE

If an Employer is in compliance with LAMC 187.04(F), that Employer does NOT need to complete this request form. For more information, please refer to the Paid Sick Leave section of the Frequently Asked Questions document available on our website (http://wagesla.lacity.org).

SECTION I: GENERAL INFORMATION

1. Requesting Group Type: ☐ Employer ☐ Attorney: _____ ☐ Other: _____	2. Employer Name: 3. Industry Type: 4. EIN: - 5. Phone: ( ) - 6. Address:
7. Contact Name:	8. Mailing Address:
9. Contact Phone: ( ) -	10. Contact Email:

SECTION II: DETERMINATION CRITERIA

11. Have all Employees for whom this determination is requested been notified of and offered access to a combined paid and/or unpaid sick leave totaling 48 hours per year that can be taken with no adverse action?

☐ Yes ☐ No. Explain:

12. Complete the chart below with as much applicable information as possible.

EMPLOYEE CATEGORY	# 1	# 2	# 3	# 4	# 5
A. TRADE/TYPE OF WORK					
B. CLASSIFICATION TYPE					
C. STEP					
D. EMPLOYMENT STATUS					
E. COMPENSATED TIME OFF TOTAL HOURS AND TYPES INCLUDED IN THIS TOTAL	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____
F. HOURLY WAGE RATE	$	$	$	$	$
G. HEALTH & WELLNESS FUND	$	$	$	$	$
H. PENSION FUND	$	$	$	$	$
I. VACATION & HOLIDAY FUND	$	$	$	$	$
J. ADDITIONAL BENEFITS	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____
K. OTHER:					
L. OTHER:					

13. Additional Comments:

SECTION III: SIGNATURE

I declare under penalty of perjury under the laws of the State of California that the information provided on this form is true and correct to the best of my knowledge.

Print Name	Title/Affiliation	Signature	Date

Print Form

MINIMUM WAGE ORDINANCE PAID SICK LEAVE DETERMINATION REQUEST FORM: ATTACHMENT # ____

Representative Name: _____ **Employer Name:** _____

EMPLOYEE CATEGORY	# _____	# _____	# _____	# _____	# _____
A. TRADE/TYPE OF WORK					
B. CLASSIFICATION TYPE					
C. STEP					
D. EMPLOYMENT STATUS					
E. COMPENSATED TIME OFF TOTAL HOURS AND TYPES INCLUDED IN THIS TOTAL	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____	TOTAL HOURS: _____ ☐ Vacation ☐ Sick Leave ☐ Paid Time Off ☐ _____
F. HOURLY WAGE RATE	$	$	$	$	$
G. HEALTH & WELLNESS FUND	$	$	$	$	$
H. PENSION FUND	$	$	$	$	$
I. VACATION & HOLIDAY FUND	$	$	$	$	$
J. ADDITIONAL BENEFITS	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____	☐ Health Benefit at no cost to the Employee ☐ Retirement Package ☐ Flexible Schedules ☐ Deferred Compensation Package ☐ _____
K. OTHER:					
L. OTHER:					

Additional Comments: