

**DEPARTMENT OF TRANSPORTATION  
EMPLOYEE CLAIM FOR WAGE RESTITUTION**

OMB Control No. 2105-0517  
Expiration Date: May 31, 2003

This collection of information is mandatory and will be used to fulfill the requirements of the Transportation Acquisition Regulation (TAR). Public reporting burden is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the FAR Secretariat (VRS), Office of Federal Acquisition and Regulatory Policy, GSA, Washington, D.C. 20405; and to the Office of Management and Budget, Information and Regulatory Offices, 725 17th Street, NW, Washington, DC 20503. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection is 2105-0517.

**TO: The General Accounting Office  
Claims Division  
Washington, DC 20548**

**CONTRACT NUMBER**

**DATE OF CLAIM**

**EMPLOYEE'S FULL NAME**

**SSN:**

I hereby make claim for payment of unpaid wages due me in the amount of \$ \_\_\_\_\_

as an employee of \_\_\_\_\_  
*(Name of Contractor and/or Subcontractor)*

performing work under the above number at \_\_\_\_\_  
*(location of work)*

\_\_\_\_\_, I was employed

as \_\_\_\_\_ during the period from \_\_\_\_\_  
*(job title) (month/day/year)*

to \_\_\_\_\_  
*(month/day/year)*

This claim constitutes the total amount claimed due and unpaid for the period of employment indicated.

ADDRESS OF EMPLOYEE

SIGNATURE OF EMPLOYEE