GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF LABOR

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Labor Relations Division

Wrongful Discharge **WD-_____-_____-_____**

DATE FILED:

Applicant Information

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

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

_____
Physical Address *City/ State/Zip*

Phone: **(340)** _____ Rate of Pay: _____

Indicate Job Classification
Part time or Full Time: _____

Social Security Number:

Employer Information

Employer : _____
Name *Immediate Supervisor*

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

Phone: **(340)** _____ Period Employed : _____
Fax: **( )** _____

Special Needs Required:

_____

Facts on which the Complaint is based. (Be specific as to facts, names, dates, etc.)

I. *"The relief being sought is reinstatement with back pay pursuant to Title 24 V.I.C. § 77(c)"*

II. I believe I was wrongfully discharged or resigned for the following reasons: (**explain in your own words**)

The **Rules and Regulations under Title 24 V.I.C. Section 76 et. Seq. mandates in part that the Complainant must communicate promptly to the Division of Hearings and Appeals any change in their name, mailing address, or daytime telephone number. A party who fails to furnish such information shall be deemed to have waived the right to notice and service under the rules V.I.R. & Regs. Title 24 § 77-21 (1991)**

I swear or affirm that I received a copy of the Wrongful Discharge Act. I have read the above complaint and it is true to the best of my knowledge, information and belief.

SUBSCRIBED AND SWORN TO BEFORE ME

this _____ ***day of*** _____

_____.
(year)

_____ _____
Signature of Complaint **Notary Public**

[ ] Employer has (5) five or more employees
[ ] Complainant worked more than (6) six months
[ ] No Union or Contract
[ ] Complainant was not a Supervisor