VIRGIN ISLANDS DEPARTMENT OF LABOR
DIVISION OF LABOR RELATIONS
COMPLAINT OF WRONGFUL DISCHARGE
(Title 24 Virgin Islands Code Sections 76 and 77)

CASE: _____
CASE Number: _____
DATE FILED: _____

EMPLOYER (against whom the Complaint is filed):

Name: _____ Address: _____
_____

Authorized Representative/Supervisor:
_____

Job Title: _____ Telephone Number:_____

EMPLOYEE filing the Charge:

Name: _____ Address: _____

Job Title: _____

Social Security No: _____ Tel. No.:_____

Full Time ( ) Part Time ( ) Hours of Work:_____ Rate of Pay (month/hr) _____

Relief Sought: Reinstatement ( ) Back Pay ( ) Other ( ) {specify}_____

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

I. I was employed from:_____
II. My Job Classification was:_____
III. On the____day of_____, 200__, I was dismissed from my employment by, Mr./Ms. _____, Job Title, _____.
IV. I believe I was wrongfully discharged for the following reasons,

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 _____of_____, 2005.
(day) (month)

_____
Signature of Complainant

_____
NOTARY PUBLIC