GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
◆

DEPARTMENT OF LABOR

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Division of Labor Relations

Wrongful Discharge

WD-______-______-_____

Applicant Information

Full Name: ____

Last *First* *M.I.*

Address: ____

Mailing Address *City/ State/Zip*

____

Physical Address *City/ State/Zip*

Phone: ____________________ Email: ____________________

Indicate Job Classification
Part time or Full Time and Rate
of Pay: ____________ **/** ____________ **/ $** ________ **per hour**

Employer Information

Employer : ____

Company Name *Immediate Supervisor*

____

Mailing Address *City/ State/Zip*

Phone: ____________________ Period Employed : ________ **to** ________

Email: ____________________

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 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 under penalty of perjury, 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.***

____
Signature of Complaint

Employer has (5) five or more employees

Complainant worked more than (6) six months

ID Verified

No Union or Contract

Complainant was not a Supervisor

Last four numbers of SS or DL