STATE OF HAWAI'I – Ka MOKU`ĀINA `O HAWAI`I
CRIME VICTIM COMPENSATION COMMISSION
Ke Komikina Uku Luaahi Kalaima
1164 Bishop Street, Suite 1530 / Honolulu, Hawai'i 96813
Telephone: (808) 587-1143 / Fax: (808) 587-1146

FORM #3

AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

This Section should be completed by the **APPLICANT** and given to your **EMPLOYER** for completion.

I, _____, [DOB: _____, SSN: _____]
(Victim's First Name, M.I., Last Name)
authorize my employer, _____
_____
_____
(Full Name and Complete Mailing Address of Employer)
to release information to the Crime Victim Compensation Commission (CVCC) regarding my absence from work based on an incident which occurred on _____.

_____
Signature Date

After completing the top portion of this form, please give the form to your employer to complete and return to the Commission.

This Section should be completed by the **EMPLOYER** and returned to the **Crime Victim Compensation Commission.**

Employee's Job Title: _____.

The Employee was absent from _____ to _____ and returned to work on _____.

He/She was scheduled to work on (specify days/dates employee was scheduled to work during this period)

_____.

During the above period of absence, the employee **would have received** $_____ in gross earnings,

Based on $_____ per hour, _____ hours per day, _____ days per week.

Did the employee receive any of the following benefits?
(Please indicate gross amounts received. If **not eligible**, please indicate reason(s) for denial.)

Vacation Leave / Sick Pay $_____ Dates received for/Denial Reason: _____

Paid Holidays $_____ Dates received for/Denial Reason: _____

Temporary Disability $_____ Dates received for/Denial Reason: _____

Workers' Compensation $_____ Dates received for/Denial Reason: _____

Form Completed by: (Please PRINT or TYPE)

_____
(Name of Person Completing Form) (Title of Person Completing Form)
Signature _____

Telephone Number _____ Date Completed _____