



STATE OF HAWAII  
**CRIME VICTIM COMPENSATION  
COMMISSION**

1136 Union Mall, Suite 600 / Honolulu, Hawai'i 96813  
Telephone: (808) 587-1143 / Fax: (808) 587-1146

MARI MCCAIG  
Chair

THOMAS T. WATTS  
Member

L. DEW KANESHIRO  
Member

PAMELA FERGUSON-BREY  
Executive Director

**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 \_\_\_\_\_