CONFIDENTIAL

State of Hawaii Application for Victims Protections-Victims Leave

Name:		Telephone No.:	
Other Contact Information:			
Job Title/Department/Location:			
1.	Application request for: (Please check all that apply)		
	Victims Leave-Sick		
	Victims Leave-Vacation		
	Victims Leave-Comp Time Off		
	Victims Leave-Leave without Pay		
2.	Period of leave (month/day/year) and total number of working hours being utilized for Victims Leave:		
	Beginning: End	ding:	
	Total number of working hours:		
3.			
	Seek medical attention for myself or my minor child to recover from physical or psychological injury or disability caused by domestic or sexual violence		
	Obtain services from a victim services organization		
	Obtain psychological or other counseling		
	Temporarily or permanently relocate	Temporarily or permanently relocate	
	Take legal action, including preparing for or parti proceeding related to or resulting from the dome to enhance the physical, psychological, or econo minor child or to enhance the safety of those who	stic or sexual violence, or other actions mic health or safety of myself or my	
4.	4. Certification	Certification	
	I certify that the above information is true and accurate:		
	Employee's Signature	Date	
5.	5. Determination		
	Approved		
	Disapproved		
	Supervisor's Signature	Date	
OFFICE USE ONLY Received by: Date:			