



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
WAGE STANDARDS DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 340, Honolulu, Hawaii 96813
INSTRUCTION SHEET FOR WSD-1.398 COMPLAINT FORM
Chapter 398, Family Leave Law

Instructions

Note: For a family leave complaint, you must file within 90 days of either: (1) the date of the alleged violation, or (2) the date you learned of the alleged violation.

Please completely fill out the WSD-1.398 Complaint Form.

Please type or print legibly. Read all instructions before completing the form. If you have any questions, call the nearest office at the number listed below.

WSD-1.398 Complaint Form

Note: A copy of your complaint will be given to the employer.

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|----------------------|--|
| Items 1 through 9: | Provide information pertaining to yourself. |
| Items 10 through 14: | Provide information about the employer you are filing a complaint against. |
| Items 15 through 24: | Provide information about the nature of your complaint. |

Page 2 of 2:

Statement of facts:

- (a) Briefly state the alleged violation.
- (b) Describe how the employer committed the alleged violation by providing a brief summary of the pertinent instances or examples which support your allegation.

Verification and Signature:

- Your complaint must be verified by an authorized Department of Labor and Industrial Relations representative. You will be required to produce identification. If you mail your complaint, it must be signed before a notary public.
- Check box if complainant is under 18 years old. If legal action becomes necessary, a parent or legal guardian must sign an assignment.

IMPORTANT: Report any change of address or telephone number. If we are unable to contact you, your case will be closed.

The Delivery Information section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly. Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail or In Person. Complaints may not be filed by fax.
Department of Labor and Industrial Relations, Wage Standards Division

Oahu	830 Punchbowl Street, Rm. 340; Honolulu, HI 96813	Phone: (808) 586 - 8777
Hilo	State Building, 75 Aupuni Street; Rm. 108; Hilo, HI 96720	Phone: (808) 974 - 6464
Kauai	3060 Eiwa Street; Rm. 202; Lihue, HI 96766	Phone: (808) 274 - 3351
Maui	2264 Aupuni Street; Wailuku, HI 96793	Phone: (808) 984 - 2075
West Hawaii (Kona)	Post Office Building; P.O. Box 49; Kealahou, HI 96750	Phone: (808) 322 - 4808



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
WAGE STANDARDS DIVISION
WSD-1.398 COMPLAINT FORM
Chapter 398, Family Leave Law

Complainant Information: Please print or type

1. Name (Last, First Middle Initial) <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.			2. Last four digits of Social Security No. XXX-XX-		
3. Address			City	State	Zip Code
4. Phone ()	Cell Phone ()	Email Address			
5. Type and Title of Work Performed			6. Employment Status <input type="checkbox"/> Current Employee of Employer Named Below <input type="checkbox"/> Quit <input type="checkbox"/> Discharged		
7. If No Longer Employed, Reason					
8. Date(s) Period of Employment: From: To:		9. Union Membership <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of Union:			

Employer Information:

10. Business Name					
11. Address			City	State	Zip Code
12. Phone ()	Fax ()	Cell ()			
13. Name and Title of Owner or Person in Charge					
14. Nature of Business					

Complaint Information:

15. Qualifying reason you requested family leave: <input type="checkbox"/> Birth of a child <input type="checkbox"/> Adoption of a child <input type="checkbox"/> To care for a child, spouse, reciprocal beneficiary, sibling, grandchild, or parent with a serious health condition					
16. Alleged violation(s) - Check those that apply and explain: <input type="checkbox"/> Refusal to properly grant family leave <input type="checkbox"/> Denial of use of accrued and available sick leave <input type="checkbox"/> Refusal to restore same or equivalent position <input type="checkbox"/> Other <input type="checkbox"/> Failure to maintain or restore equivalent benefits <input type="checkbox"/> Refusal to authorize substitution of accrued paid leave (such as vacation) upon employee election					
17. Explanation of circumstances and related details of the alleged violation(s) above:					
18. Date of alleged violation:			19. Date of discovery of alleged violation:		
20. If your employer required certification for family leave, was it provided? <input type="checkbox"/> Yes <input type="checkbox"/> No			21. Type of employer: <input type="checkbox"/> Private Sector <input type="checkbox"/> Public Sector <input type="checkbox"/> State <input type="checkbox"/> County		
22. Approximately how many employees does the employer have?					
23. Months of consecutive employment at the time of violation:					
24. Were you covered by a collective bargaining agreement?					

FOR OFFICE USE ONLY			Law				
Date Received			ICB				
			CS				
Taken by		DOL #:	IS1		IS2		
	H K M WH		HB			No.	

WSD-1.398 COMPLAINT FORM

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Statement of Facts (Briefly explain pertinent facts of the alleged violation):

I swear or affirm that I have read this complaint, and that the information and statements are true to the best of my knowledge and belief. I authorize the Director of Labor and Industrial Relations or a departmental representative to collect and receive, on my behalf, payments made on my complaint.

Note: Do not date or sign unless in the presence of an authorized DLIR representative or a notary public.

Date: _____ Signature of Complainant: _____

Check if under 18 years old

FOR OFFICE USE ONLY

VERIFIED BY: _____ <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Authorized DLIR Representative Date </div>
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FOR NOTARY PUBLIC:

STATE OF HAWAII)) SS. _____ COUNTY OF _____) On this _____ day of _____, 20____, before me personally appeared _____ and _____, to me known to be the person(s) described herein, and who, being duly sworn, did say that he/she/they is/are the said _____ named in the foregoing instrument, and that he/she/they executed said instrument as his/her/their own free act and deed.	_____ (Signature) Notary Public, State of Hawaii My commission expires: _____
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Document Date: _____ # of Pages: _____ Printed Notary Name: _____ Circuit _____ Document Description: _____ _____ _____ Notary Signature _____ Date _____	(Stamp or Seal)
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NOTARY CERTIFICATION