GENERAL APPEAL FORM

APPELLANT INFORMATION (Person or group making appeal)

1. Appellant:
   If several individuals are appealing together, list the additional names, addresses, and numbers on a separate sheet and identify a representative in #2 below. If an organization is appealing, indicate the group's name, addresses, and numbers here and identify a representative in #2 below.

   Name ____________________________________________________________________
   Address _____________________________________________
   ______________________
   ______________________________________________________
   Phone: Work:______________________ Home: _____________________________
   Fax: _____________________ Email Address: _____________________________

   In what format do you wish to receive documents from the Office of Hearing Examiner?
   Check One: _____ U.S. Mail _____ Fax _____ Email Attachment

2. Authorized Representative:
   Name of representative if different from the appellant indicated above. Groups and organizations must designate one person as their representative/contact person.

   Name __________________________________________
   Address __________________________________________________________________
   ______________________________________________________
   Phone: Work:______________________ Home: _____________________________
   Fax: _____________________ Email Address: _____________________________

   In what format do you wish to receive documents from the Office of Hearing Examiner?
   Check One: _____ U.S. Mail _____ Fax _____ Email Attachment

DECISION BEING APPEALED

1. Decision appealed (Departmental File or Reference #.): __________________________

2. Address (if any) connected to decision being appealed:
   __________________________________________________________

3. Type of issue/decision being appealed if known (ask for assistance if unknown):
   __________________________________________________________

(over)
APPEAL INFORMATION

Answer each question as completely and specifically as you can. Attach separate sheets if needed and refer to questions by number.

1. What is your interest in this appeal? (State how you are involved or affected by it)
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

2. What are your objections to the issue being appealed? (List and describe what you believe to be the errors, omissions, or other problems and issues involved.)
   __________________________________________________________________________
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   __________________________________________________________________________

3. What relief do you want? (Specify what you want the Examiner to do: reverse the decision, modify conditions, etc.)
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Signature ___________________________ Date ___________________________

Deliver or mail appeal and appeal fee to:

Mailing Address: City of Seattle
                 Office of Hearing Examiner
                 P.O. Box 94729
                 Seattle WA 98124-4729

Physical Address: SEATTLE MUNICIPAL TOWER
                 700 5th Avenue, Suite 4000
                 40th Floor
                 Seattle, WA 98104

Note: Appeal fees may also be paid by credit or debit card over the phone (Visa or MasterCard only).

Phone: (206) 684-0521       Fax: (206) 684-0536       www.seattle.gov/examiner