

**GENERAL APPEAL FORM**

*It is not required that this form be used to file an appeal. However, whether you use the form or not, please make sure that your appeal includes all the information/responses requested in this form. An appeal, along with any required filing fee, must be received by the Office of Hearing Examiner, not later than 5:00 p.m. on the last day of the appeal period or it cannot be considered.*

**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):  
\_\_\_\_\_  
\_\_\_\_\_

**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)

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\_\_\_\_\_  
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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.)

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

<b>PHYSICAL ADDRESS:</b>	SEATTLE MUNICIPAL TOWER 700 5 <sup>th</sup> Avenue, Suite 4000 40 <sup>th</sup> Floor Seattle, WA 98104
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**Note:** Appeal fees may also be paid by credit or debit card over the phone (Visa or MasterCard only).