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. Delivery of appeals filed by any form of USPS mail service may be delayed by several days. Allow extra time if mailing an appeal.

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.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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*