

APPEAL FORM

You do not have to use this form to file an appeal. However, if you do not use it, please make sure that your appeal includes all the information requested on this form. The appeal, along with any required filing fee, must reach the Office of Hearing Examiner, no later than 5:00 p.m. of the last day of the appeal period.

APPELLANT INFORMATION (Person or group making appeal)

1. **Appellant:**

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

Name _____

Address _____

Phone: Work: _____ Home: _____

Fax: _____ Email Address: _____

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: _____

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)

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.)

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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

Signature _____

Date _____

Appellant or Authorized Representative _____

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 4004
Seattle, WA 98104