Division of Health Benefits

APPEAL PROCEDURES FILING FORM

(Applicable only to DHB employees.)

Check *ONE*: ❑ Step-1 Second-Level Supervisor / ❑ Step-2 Division Director

1. Name (first, middle, last): _____
2. Mailing Address (include zip code): _____
3. E-mail address: _____
4. Phone Number (include area code): _____
5. Unit: _____
6. Position Title: _____
7. Immediate Supervisor: _____
8. Date of Discharge: _____
9. Desired Outcome: _____
10. Signature: _____ Date: _____

The Following to be Completed by an Authorized Person in the DHB Human Resources Office.

Received by (Name and Title): _____ Date Received: _____

Step-1 Second-Level Supervisor

Date of Review Meeting: _____

Outcome: _____

Date Employee Notified: _____

Step-2 Division Director

Date of Review Meeting: _____

Outcome: _____

Date Employee Notified: _____