

## CABINET FOR HEALTH AND FAMILY SERVICES DEPARTMENT FOR PUBLIC HEALTH

## Local Health Department Personnel Branch 275 East Main Street Frankfort, Kentucky 40621

## Request for Appeal

This appeal is hereby filed pursuant to the provisions of administrative regulation 902 KAR 8:110.

| Name(Last)                 | (First)                        | (Middle Initial  | )            | (Soc. Secu  | rity Number) |  |
|----------------------------|--------------------------------|--|--------------|-------------|--------------|--|
| Work Station Address       | (Street)                       |  | (City)       | (State)     | (Zip Code)   |  |
| Home Phone ()              |                                |  | Work Phor    |             |              |  |
| Local Health Departn       | nent                           |  |              |             |              |  |
| Name of Appointing         | Authority                      |  |              |             |              |  |
| Are You Represented        | by an Attorne                  | y 🗆 No   |              | Yes         |              |  |
| Attorney's Name            |                                |  |              |             |              |  |
| Address(Street             |                                | (C'.   | <u>(C)</u>   |             | (7' C 1)     |  |
| Phone Number ()            | ,                              | ` •  | ,            | ŕ           | (Zip Code)   |  |
| I am a:                    |                                |  |              |             |              |  |
| ☐ Regular Sta☐ Application | ntus Employee<br>n for Employm |  | □ Eligible o | on Register |              |  |
| I am Appealing the fo      | ollowing action                | s: (Check appro  | priate box o | or boxes)   |              |  |
| ☐ Dismissal                | □ Rej                          | ☐ Rejection of application or removal of name from register  |              |             |              |  |
| □ Demotion                 |                                | ☐ Discrimination: Circle those that apply (Race, Color, Religion, Ethnic Origin, Sex, Disability, Political, Age, Pregnancy, |              |             |              |  |
| □ Suspension               |                                | Citizenship, Sexual Orientation)   |              |             |              |  |

| Regular Status Employee, Applicant or Eligible   |                 |
|--|-----------------|
| Please Complete This Section   |                 |
| The following is a short, plain, and concise statement of the facts which relate to appealing. | the action I am |
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|  |                 |
| Date of Receipt of Notice of Appealed Action:  | _               |
| (Attach a copy of any written notice which you received relating to this appeal)               |                 |
|  |                 |
| Signature  | Date            |
| Attorney's Signature (If Applicable)   | Date            |

## This Form is to be Mailed or emailed to:

Department for Public Health Division of Administration & Financial Management Local Health Department Personnel Branch 275 East Main Street, HS1W-D Frankfort, Kentucky 40621

LH.Personnel@KY.Gov

