

PUBLIC HEALTH AND  
SOCIAL SERVICES DEPARTMENT  
ENVIRONMENTAL HEALTH DIVISION  
2000 Lakeridge Drive SW  
Olympia, WA 98502-6045  
(360) 867-2644 TDD (360) 867-2603



---

## REQUEST FOR APPEAL TO THE THURSTON COUNTY BOARD OF HEALTH

This Application is a request for appeal of an Administrative Hearing Decision. This appeal is scheduled before the Board of Health and **requires a \$775.00 non-refundable fee**. The appeal must be filed within 15 days of the date of the Administrative Hearings Officer decision and a hearing before the Board of Health will be held within 50 days of the date the appeal was filed.

DATE: \_\_\_\_\_

### **Party of Record Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Appeals to the Board of Health are closed record hearings. **The appeal application, memorandum, and other materials shall not include any new evidence and shall be based only upon facts presented to the hearing officer.**

**The following information must be submitted for appeals before the Board of Health:**

- Complete Application
- Appeal fee of \$775.00 (non-refundable)

**State how the appellant is aggrieved and has standing to appeal:**

----- Continued On the Reverse Side -----

Concisely state the issues being appealed, stating the specific exceptions and objections to the hearing officer's decision being appealed. Reference the provisions of the hearing officer's decision which are being appealed, citing the specific section(s), paragraph(s) and page(s):

State the specific relief requested:

If you wish to submit a written memorandum for consideration by the Board of Health, it must be submitted along with this application.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Receipt Date: \_\_\_\_\_ Fee Paid: \_\_\_\_\_ Receipt Number: \_\_\_\_\_ By: \_\_\_\_\_