STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
OLYMPIA, WASHINGTON 98504-0095

Administrative Hearing Withdrawal

Date: _____ Client ID Number: _____

Name: _____ Docket Number: _____

_____

Mailing Address: _____
STREET CITY ZIP CODE

I hereby request that my Administrative Hearing scheduled at _____ on _____ , _____.
TIME MONTH AND DAY YEAR

at _____ be withdrawn because:
COMMUNITY SERVICES OFFICE (CSO)

If you have any questions, please call _____, your Administrative Hearing Coordinator, at

_____.

Please sign and return this withdrawal request in the enclosed postage paid envelope as soon as possible.

_____
CLIENT'S SIGNATURE

_____
TELEPHONE NUMBER

DSHS 02-528 (REV. 07/2009)

COPIES TO: Office of Administrative Hearings; Client; and Case Record