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| 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| at  be withdrawn because: | |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) | |

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| 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 |