

# Misconduct/Grievance Appeal To Administrative Review Authority

---

Offender Name: \_\_\_\_\_

DOC Number: \_\_\_\_\_

Facility Where Offense/Grievance Occurred:  
\_\_\_\_\_

Offense Code: \_\_\_\_\_

Date of misconduct violation: \_\_\_\_\_

Facility Misconduct Appeal Number  
\_\_\_\_\_

Facility Grievance Appeal Number  
\_\_\_\_\_

---

I received the response of the reviewing authority at the facility on: \_\_\_\_\_

Fill out this form in blue or black ink. Writing must be legible. I wish to appeal the reviewing authority's response to the misconduct/grievance on the following ground(s) only. DO NOT ATTACH ANY OTHER PAGES. (Use ONLY the back side of this page, if necessary). Your appeal will be returned to you unanswered if any other pages are submitted.

Newly discovered/available evidence not considered by the reviewing authority, relevant to the issue, necessary for a proper decision, and why the evidence was not previously available which if considered may alter the decision (you must clearly state the newly discovered/available evidence); or

Probable error committed by the reviewing authority in the decision such as would be grounds for reversal (you must clearly state the error committed by the reviewing authority, including citing the part of procedures or statutes not followed by the reviewing authority).

**Response:**

---

---

---

---

---

---

---

---

---

---

I understand that in accordance with OP-060125/OP-090124, I will be charged \$2 to appeal a misconduct/grievance to the Administrative Review Authority or Chief Medical Officer, and that this form is also a request for disbursement of funds from my trust fund draw account. If I do not have enough funds to cover this cost, the amount will be collected as soon as funds become available.

\_\_\_\_\_  
Signature of Offender

\_\_\_\_\_  
Date