Attachment 7
Form 5 A.P. 2-2 Appeal to City Motor Vehicle Incident/Disqualification Committee

A.P. 2-2 Form 5

APPEAL TO THE CITY MOTOR VEHICLE INCIDENT/DISQUALIFICATION COMMITTEE

I, ________________________, Empl # _______ and/or the _________________________ Department hereby appeal(s) the Determination of the Departmental Review Panel that Employee ___________________ ________________ caused a motor vehicle incident, and/or is _________________________ disqualified from Driving.

I understand that I will provide to the Committee at least 2 days before my scheduled appeal hearing date, copies of all the relevant documents related to the appeal of this issue that I would like the Committee to consider. I certify that these same documents were presented to the Departmental Review Panel at the time of the Panel Meeting. I will inform my representative and witnesses of the date and time for the appeal hearing.

Although not required or necessary, I choose to be represented by ________________________________.

____
Date

____
Employee Signature or Departmental Representative

____ Address (not P.O. Box) City, State, Zip for the City Motor Vehicle Incident/Disqualification Committee Hearing Confirmation

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I certify that this Appeal was received by me on the ______ day of _______________________, ____.

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Human Resources Representative