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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| at  be withdrawn because: |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 |