REQUEST FOR AN ADMINISTRATIVE HEARING

DEPARTMENT OF HEALTH AND HUMAN SERVICES
EARLY CHILDHOOD SERVICES
SFN 1172 (3-2025)

Clear Fields

		Type of Appeal ☐ Revocation ☐ Denial	
Name		Telephone Number	
Street Address	City	State	ZIP Code
Address Where Care is Provided	City	State	ZIP Code

I, the above-named, have been ☐ registered ☐ licensed ☐ self-declared to provide Early Childhood Services at above care-provided address. The Department of Health and Human Services has notified me of the revocation/denial of my ☐ registered ☐ licensed ☐ self-declared on _____

I do not agree with this action of the Department of Health and Human Services and I request an administrative hearing for the following reasons: (State specific reason you are appealing.)	
Signature of Appellant	Date

Send original to:

Attn: Appeals Supervisor
Department of Health and Human Services
600 East Boulevard Avenue Dept. 325
Bismarck, ND 58505-0250

Email: dhslau@nd.gov
Fax: 701-328-2173