REQUEST FOR AN ADMINISTRATIVE HEARING

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
EARLY CHILDHOOD DIVISION
SFN 1172 (5-2022)

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 Human Services has notified me of the revocation/denial of my ☐ registration ☐ license ☐ self-declaration on _____ .

I do not agree with this action of the Department of 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
North Dakota Department of Human Services
600 East Boulevard Avenue Dept. 325
Bismarck, ND 58505-0250

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