For office use only
Date received: _____

STEP – APPENDIX FORM G

Request for Review of the Decision

Concerning Student _____ Date of Birth _____ Age _____
School _____ Grade _____
Parents/Guardians_____
Home Address _____
Home Phone _____ Cell Phone _____
Email _____

IMPORTANT: THIS FORM MUST BE SUBMITTED WITHIN TEN (10) DAYS OF THE PRINCIPAL'S WRITTEN DECISION IN REGARDS TO A DISABILITY DISCRIMINATION COMPLAINT. THE REQUEST MUST BE SENT TO THE DEPARTMENT OF CATHOLIC SCHOOLS AT THE ADDRESS BELOW.

I/we, _____,

Parent(s)/guardian(s) of _____,

request a review of Principal _____'s,
(School Principal's Name)

written decision of the Disability Discrimination Complaint dated _____.

The reason we are requesting a review is:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Attach additional sheets for details if needed. Mail complaint/documents to your principal and to:
Archdiocesan Compliance Officer
Department of Catholic Schools
3424 Wilshire Blvd., Floor 2
Los Angeles, CA 90010