For office use only
Date received: _______

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

Copyright © 2018 The Roman Catholic Archbishop of Los Angeles, a corporation sole. All rights reserved.