

COMMONWEALTH OF KENTUCKY  
Cabinet for Health and Family Services  
Office of Inspector General  
Division of Regulated Child Care

Certified Family Child-Care Home Request for Appeal

For Official Use Only  
DATE RECEIVED BY DRCC

NAME: \_\_\_\_\_  
(last name) (first name)

CERTIFIED  
FAMILY CHILD \_\_\_\_\_  
CARE HOME: \_\_\_\_\_  
(street address or P O Box number)

MAILING  
ADDRESS: \_\_\_\_\_  
(city) (state) (zip code)

CERTIFICATION NUMBER: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

CELL PHONE NUMBER: \_\_\_\_\_

REPRESENTED BY ATTORNEY:  NO  YES

ATTORNEY'S NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
(Street address or P O Box number)

\_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip code)

PHONE NUMBER: \_\_\_\_\_

I AM APPEALING THE FOLLOWING ACTIONS: (Check appropriate box/boxes)

EMERGENCY SUSPENSION  
 DENIAL OF CERTIFICATION  
 REVOCATION OF CERTIFICATION  
 OTHER (Specify): \_\_\_\_\_



