

Michigan Department of Licensing and Regulatory Affairs  
Bureau of Health Systems

**APPEAL OF A NOTICE OF AN INVOLUNTARY TRANSFER OR DISCHARGE**

I hereby appeal and request a hearing due to a *Notice of Involuntary Transfer or Discharge* from this facility or a distinct part of the facility.

Please type or print:

Person Requesting Appeal		
Street Address of Person Appealing		
City	State	Zip Code
Daytime Telephone		
Resident		
Facility Name		
Facility Street Address		
City	State	Zip Code
Date Notice Received		
<b>Signature of Person Requesting Appeal</b> X		
Date (must be within 10 days of receipt of notice)		
Relationship to Resident <input type="checkbox"/> Resident <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Other (explain)		

**Return completed form to:**

Michigan Department of Licensing and Regulatory Affairs  
Bureau of Health Systems, Division of Operations  
Complaint Investigation Unit  
P.O. Box 30664  
Lansing, Michigan 48909  
(Street Address: 611 W. Ottawa Street; Lansing, Michigan 48933)

If you have any questions regarding this procedure you may call the Involuntary Transfer Coordinator with the Division of Operations at (517) 241-4712 or send a fax to (517) 241-0093 for assistance.