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|  | **Education Appeal** |

Use this form to appeal a decision made regarding an education, training or ECEAP staff qualifications application that you completed in MERIT. Submit your appeal form within **60 days** of the decision. Review the policy for education and training appeals for more information or questions regarding your ECEAP staff qualifications application appeal please email [ECEAP@dcyf.wa.gov](mailto:ECEAP@dcyf.wa.gov)

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| --- | --- |
| First Name: | Last Name: |
| STARS ID: | Date of Birth (mm/dd/yyyy): |

## INSTRUCTIONS

Print or type your response in the field below, sign at the bottom of the form, and then email the completed form to:

* Education Application appeals are emailed to [education.verification@centralia.edu](mailto:education.verification@centralia.edu)
* Trainer Approval and Training appeals are emailed to [MERIT@dcyf.wa.gov](mailto:MERIT@dcyf.wa.gov)
* ECEAP Staff Qualification appeals are emailed to [ECEAP@dcyf.wa.gov](mailto:ECEAP@dcyf.wa.gov)

## REASON FOR APPEAL

Please use the space below or attach a separate document to address the reason for your appeal. Be sure to include your name and STARS ID on all supporting documents that you provide.

## The reason I am applying for an appeal is because I believe:

My education was incorrectly recorded

I am eligible for an Education Award that I did not receive

My training was incorrectly recorded

My ECEAP staff qualifications were incorrectly recorded

## Please address the following questions:

What is the reason you think the action taken was not correct?

What is your desired outcome?

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## Statement of Understanding

* The information I provided is true and accurate and may become public upon request.
* All documentation submitted to DCYF will become the property of DCYF and will not be returned.
* If an alternate decision is made, I authorize DCYF to enter this information into MERIT.
* Any documentation that appears to have been altered, or on which “white out” is used, will not be processed or verified.
* I understand no awards will be revised or paid based on previous policy; this includes the Career Lattice of 2014.

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| Signature: |  | Date: |
| **If under 18 years of age:** | |  |

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| Parent/Guardian Signature (required if under18): |  | Date: |
| Parent/Guardian Name (please print): |  |  |

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| For internal DCYF use only  |  |  |  |  | | --- | --- | --- | --- | | Professional’s Name: |  | STARS ID: |  | |  |  |  |  | | Based on the review, DCYF has made the following decision (check one): | | | | |  | Approved Denied |  |  |  |  |  |  |  | | --- | --- | --- | --- | | Professional was notified on: |  | by: | Email  Phone or Voicemail | |  | Date |  |  | | I completed a thorough review, followed up with the professional and noted the outcome of the professional’s MERIT record.  Processed by (printed name of DCYF employee): | | | | |