PEN PROGRAM

Professional **E**xcellence in **N**ursing

APPEAL FORM

NAME _____

UNIT _____ DEPT. EXT._____

HOME PHONE _____

STATEMENT CONCERNING APPEAL: Please respond to the deficiencies listed on your notice of denial for PEN advancement. Make your statement accurate, brief, and legible. This appeal must be submitted to Nursing Administration, MLA 245, attn: Nicolasa Wilson, within 14 days from notification of denial.

DATE _____

_____ I would like a hearing to be scheduled. _____

_____ I waive my right to a hearing. Signature

DECISION: DATE _____

Final Decision by Appeal Board: Appeal Denied _____ Advancement to PEN Accepted _____

Signed _____
Appeal Board Member

KAR 2.11.2015