## STATE OF CALIFORNIA INMATE/PAROLEE HEALTH CARE APPEAL FORM CDCR 602-HC (08/08)

## DEPARTMENT OF CORRECTIONS AND REHABILITATION CALIFORNIA PRISON HEALTH CARE SERVICES

Category:

Side 1

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		2.		150-krenaushirosopiety gyv4
u may appeal any policy, action	or decision which has a	slonificant adverse affect up	on you. This form shall be	used when the policy, action or decision
ing appealed involves health care	e services (medical, denta	il, or mental health). You m	ust first informally seek relie	f through discussion with the appropriat send your appeal with all the supporting
cuments and not more than one a	additional page of commer	nts to the Health Care Appea	als Coordinator within 15 day	s of the action taken. No reprisals will b
en for using the appeals procedu				UNIT/ROOM NUMBER
VAME	NUMBER	ASSIGNMENT		
A. Describe Problem:				
APPENDICULATION AND APPENDICULATION AND APPENDICULATION APPEND				
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f you need more space, attach or	ne additional sheet.			
3. Action Requested:				
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nmate/Parolee Signature:	· · · · · · · · · · · · · · · · · · ·	······································	Date Submitted:	
. INFORMAL LEVEL (Date Re				
Staff Response:		Waster to the southern test have a second of the southern test to the southern test test to the southern test test to the southern test test test to the southern test test test test test test test tes		A Company of the Comp
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	**************************************		Date Returned to Inmate	
D. FORMAL LEVEL:	nalnu atach sunnadina	documents (Health Care S	arvica Raguaet Form CDC	7362, Comprehensive Accommodation
Chrono, CDC 7410, Trust Accou	int Statement, etc.) and s	ubmit for processing to the	Health Care Appeals Coordi	inator at your location within 15 days of
eceipt of response.				
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nmate/Parolee Signature :			Date Submitted:	2200000 p.m. 100000000000000000000000000000000000
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Location: Institution/Parole Region:

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Side 2

FIRST LEVEL: Granted G	P. Granted	Denied [	Other	
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Staff Signature:		Title	*	Date Completed:
Division Head Approval Signature:	***************************************	Title	* * * * * ** * * * * * * * * * * * * *	Date Returned to Inmate:
F. If dissatisfied, explain reasons for your location within 15 days of received	or requesting a S pt of response:			rocessing to the Health Care Appeals Coordinato
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			4. 4. 4	
Inmate/Parolee Signature :	positivity of the same of the	· · · · · · · · · · · · · · · · · · ·		Submitted :
SECOND LEVEL:	☐ P. Granted	☐ Denled		
G. REVIEWER'S ACTION (Complete	within 20 workir	ig days): Date a	ssigned:	Due Date:
☐ See Attached Letter				
Signature:	- CANON TOWNSHIP AND THE CONTROL OF		Date Com	pleted:
Health Care Services Hiring Authority Signature:	***************************************		Títle:	Date Returned to Inmate:
H. If dissatisfied, add data or reaso				by mail to the third level within 15 days of receipt
response:	***************************************	·	The state of the s	
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S. C.	· · · · · · · · · · · · · · · · · · ·	···		
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Inmate/Parolee Signature:			Date Sut	omitted:
For the Director's Review of Health Ca	•		P O Box 4038	Appeals Health Care 12-4038
DIRECTOR'S ACTION: Granted Granted Letter	☐ P. Granted			EX. II. (Mathy III (Mathy) — 1 April
Those virginish falls!				Date:
				Date,