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

DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA PRISON HEALTH CARE SERVICES

Side 1

Location: Institution/Parole Region:	Log #:	Category:
1. _____	1. _____	_____
2. _____	2. _____	

You may appeal any policy, action or decision which has a significant adverse affect upon you. This form shall be used when the policy, action or decision being appealed involves health care services (medical, dental, or mental health). You must first informally seek relief through discussion with the appropriate staff member or by utilizing the health care service processes at your institution. If you are not then satisfied, you may send your appeal with all the supporting documents and not more than one additional page of comments to the Health Care Appeals Coordinator within 15 days of the action taken. No reprisals will be taken for using the appeals procedure responsibly.

NAME	NUMBER	ASSIGNMENT	UNIT/ROOM NUMBER

A. Describe Problem: _____

If you need more space, attach one additional sheet.

B. Action Requested: _____

Inmate/Parolee Signature: _____ Date Submitted: _____

C. INFORMAL LEVEL (Date Received _____):

Staff Response: _____

Staff Signature: _____ Date Returned to Inmate: _____

D. FORMAL LEVEL:

If you are dissatisfied, explain below, attach supporting documents (Health Care Service Request Form, CDC 7362, Comprehensive Accommodation Chrono, CDC 7410, Trust Account Statement, etc.) and submit for processing to the Health Care Appeals Coordinator at your location within 15 days of receipt of response.

Inmate/Parolee Signature : _____ Date Submitted: _____

CDCR Appeal Number

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Side 2

FIRST LEVEL: ☐ Granted ☐ P. Granted ☐ Denied ☐ Other _____

E. REVIEWER'S ACTION (Complete within 30 working days): Date assigned: _____ Due Date: _____

Interviewed by: _____

Staff Signature: _____ Title: _____ Date Completed: _____

Division Head Approval
Signature: _____ Title: _____ Date Returned to Inmate: _____

F. If dissatisfied, explain reasons for requesting a Second-Level Review, and submit for processing to the Health Care Appeals Coordinator at your location within 15 days of receipt of response:

Inmate/Parolee Signature : _____ Date Submitted : _____

SECOND LEVEL: ☐ Granted ☐ P. Granted ☐ Denied ☐ Other _____

G. REVIEWER'S ACTION (Complete within 20 working days): Date assigned: _____ Due Date: _____

☐ See Attached Letter

Signature: _____ Date Completed: _____

Health Care Services
Hiring Authority Signature: _____ Title: _____ Date Returned to Inmate: _____

H. If dissatisfied, add data or reasons for requesting a Director's Level Review, and submit by mail to the third level within 15 days of receipt of response:

Inmate/Parolee Signature: _____ Date Submitted: _____

For the Director's Review of Health Care Issues, submit all documents to:

Office of Third Level Appeals – Health Care
P O Box 4038
Sacramento, CA 95812-4038

DIRECTOR'S ACTION: ☐ Granted ☐ P. Granted ☐ Denied ☐ Other _____

☐ See Attached Letter

Date: _____