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| IAB USE ONLY | Institution/Parole Region: _____ Log #: _____ Category: _____ <hr/> <p style="text-align: center;"><i>FOR STAFF USE ONLY</i></p> |
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You may appeal any California Department of Corrections and Rehabilitation (CDCR) decision, action, condition, policy or regulation that has a material adverse effect upon your welfare and for which there is no other prescribed method of departmental review/remedy available. See California Code of Regulations, Title 15, Section (CCR) 3084.1. You must send this appeal and any supporting documents to the Appeals Coordinator (AC) within 30 calendar days of the event that lead to the filing of this appeal. If additional space is needed, only one CDCR Form 602-A will be accepted. Refer to CCR 3084 for further guidance with the appeal process. No reprisals will be taken for using the appeal process.

Appeal is subject to rejection if one row of text per line is exceeded. WRITE, PRINT, or TYPE CLEARLY in black or blue ink.

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|---------------------------|-------------------|-------------------------|-------------------|
| Name (Last, First): _____ | CDC Number: _____ | Unit/Cell Number: _____ | Assignment: _____ |
|---------------------------|-------------------|-------------------------|-------------------|

State briefly the subject of your appeal (Example: damaged TV, job removal, etc.): _____

A. Explain your issue (If you need more space, use Section A of the CDCR 602-A): _____

B. Action requested (If you need more space, use Section B of the CDCR 602-A): _____

Supporting Documents: Refer to CCR 3084.3.

Yes, I have attached supporting documents.

List supporting documents attached (e.g., CDC 1083, Inmate Property Inventory; CDC 128-G, Classification Chrono): _____

No, I have not attached any supporting documents. Reason: _____

Inmate/Parolee Signature: _____ Date Submitted: _____

By placing my initials in this box, I waive my right to receive an interview.

STAFF USE ONLY

C. First Level - Staff Use Only

Staff - Check One: Is CDCR 602-A Attached? Yes No

This appeal has been:

- Bypassed at the First Level of Review. Go to Section E.
- Rejected (See attached letter for instruction) Date: _____ Date: _____ Date: _____ Date: _____
- Cancelled (See attached letter) Date: _____
- Accepted at the First Level of Review.

Assigned to: _____ Title: _____ Date Assigned: _____ Date Due: _____

First Level Responder: Complete a First Level response. Include interviewer's name, title, interview date, location, and complete the section below.

Date of Interview: _____ Interview Location: _____

Your appeal issue is: Granted Granted in Part Denied Other: _____

See attached letter. If dissatisfied with First Level response, complete Section D.

Interviewer: _____ Title: _____ Signature: _____ Date completed: _____
(Print Name)

Reviewer: _____ Title: _____ Signature: _____
(Print Name)

Date received by AC: _____

AC Use Only
 Date mailed/delivered to appellant ___ / ___ / ___

D. If you are dissatisfied with the First Level response, explain the reason below, attach supporting documents and submit to the Appeals Coordinator for processing within 30 calendar days of receipt of response. If you need more space, use Section D of the CDCR 602-A.

Inmate/Parolee Signature: _____ Date Submitted: _____

E. Second Level - Staff Use Only

Staff - Check One: Is CDCR 602-A Attached? Yes No

This appeal has been:

- By-passed at Second Level of Review. Go to Section G.
- Rejected (See attached letter for instruction) Date: _____ Date: _____ Date: _____ Date: _____
- Cancelled (See attached letter)
- Accepted at the Second Level of Review

Assigned to: _____ Title: _____ Date Assigned: _____ Date Due: _____

Second Level Responder: Complete a Second Level response. If an interview at the Second Level is necessary, include interviewer's name and title, interview date and location, and complete the section below.

Date of Interview: _____ Interview Location: _____

Your appeal issue is: Granted Granted in Part Denied Other: _____

See attached letter. If dissatisfied with Second Level response, complete Section F below.

Interviewer: _____ Title: _____ Signature: _____ Date completed: _____
(Print Name)

Reviewer: _____ Title: _____ Signature: _____
(Print Name)

Date received by AC: _____

AC Use Only
Date mailed/delivered to appellant ____/____/____

F. If you are dissatisfied with the Second Level response, explain reason below; attach supporting documents and submit by mail for Third Level Review. It must be received within 30 calendar days of receipt of prior response. Mail to: Chief, Inmate Appeals Branch, Department of Corrections and Rehabilitation, P.O. Box 942883, Sacramento, CA 94283-0001. If you need more space, use Section F of the CDCR 602-A.

Inmate/Parolee Signature: _____ Date Submitted: _____

G. Third Level - Staff Use Only

This appeal has been:

- Rejected (See attached letter for instruction) Date: _____ Date: _____ Date: _____ Date: _____
- Cancelled (See attached letter) Date: _____
- Accepted at the Third Level of Review. Your appeal issue is Granted Granted in Part Denied Other: _____

See attached Third Level response.

Third Level Use Only
Date mailed/delivered to appellant ____/____/____

Request to Withdraw Appeal: I request that this appeal be withdrawn from further review because; State reason. (If withdrawal is conditional, list conditions.)

Print Staff Name: _____ Title: _____ Signature: _____ Date: _____

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Attach this form to the CDCR 602, only if more space is needed. Only one CDCR 602-A may be used.
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|---------------------------|-------------------|-------------------------|-------------------|
| Name (Last, First): _____ | CDC Number: _____ | Unit/Cell Number: _____ | Assignment: _____ |
|---------------------------|-------------------|-------------------------|-------------------|

A. Continuation of CDCR 602, Section A only (Explain your issue) : _____

Inmate/Parolee Signature: _____ Date Submitted: _____

B. Continuation of CDCR 602, Section B only (Action requested): _____

Inmate/Parolee Signature: _____ Date Submitted: _____

STAFF USE ONLY

