	FOR DEPARTMENT USE ONLY	
STATE OF HAWAII Department of Human Services, Socia CHILD WELFARE SERVICES BR		
Name of Worker and Phone Number:		
		불통하다 보는 그 아이에 가를 잃었다. 밤 살고
REQUES	ST FOR ADMINISTRATIVE HEARING	
Print your name and mailing address	S:	
(CWS) child abuse and/or neglect in You have the right to identify so	ring because I do not agree with the decision of the Chivestigation. omeone to be your Authorized Representative to rehat you want, complete the sentence below.	
I want	print the individual's name and mailing address	as my
Authorized Penresentative to represe	ent and act for me in the Administrative Hearing.	
Aumorized Representative to represe	ent and act for me in the Administrative Hearing.	
must return this form to the	mplete your request for an Administrative H CWS unit that is listed above within 90 cales you of your being a confirmed perpetrator	ndar days of the
Your Signature	Date	