MAINE DEPARTMENT OF CORRECTIONS

RESIDENT APPEAL OF CLASSIFICATION DECISION

Resident Name MDOC #

TO: Central Office Director of Classification, or designee, IF this is an appeal of decision about custody level, transfer to another Department facility or minimum security housing unit, or medium custody trustee status

Appeal must be postmarked within fifteen (15) days of the resident receiving the decision.

TO: Chief Administrative Officer, or designee, IF this is an appeal of decision about placement in another housing unit in the facility (other than a minimum security housing unit)

Appeal must be received by the CAO, or designee, within fifteen (15) days of the resident receiving the decision.

On _____, the following took place:

Date

Initial Classification Review

Annual or Semi-Annual Reclassification Review

Interim Reclassification Review

Decision to deny resident request for lower custody level, medium custody trustee status, or transfer

I wish to appeal for the following reasons:

| Resident's Signature | | Date | |
|---|------|------------------------|--|
| Receiving Person's Signature (if appeal to CAO, or designee) | Date | Printed Name and Title | |

MAINE DEPARTMENT OF CORRECTIONS

RESIDENT APPEAL OF CLASSIFICATION DECISION

| Resident Name | | MDOC # |
|----------------------------------|------|------------------------|
| Resident filed untimely appeal | | |
| Decision is Affirmed Reversed | | Remanded |
| | | |
| | | |
| Signature | Date | Printed Name and Title |
| If decision by CAO, or designee: | | |
| Signature of Resident | | Date |
| Signature of Staff | Date | Printed Name and Title |

NOTE: IF THIS IS DECISION BY CHIEF ADMINISTRATIVE OFFICER, OR DESIGNEE, RESIDENT IS TO BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED BY THE RESIDENT AND THE STAFF.