

AUTHORIZED REPRESENTATIVE

DR 108 (Rev. 08/12)

Please print or type.

Consumer Name

Mailing Address

Email Address

City

State

Zip Code

I request that the individual named below act on my behalf in the mediation and/or fair hearing process.

I authorize the Department of Rehabilitation to release information related to the mediation and/or fair hearing process to this authorized representative.

Consumer Signature

Date Signed



Print or type the information on the individual you want to act on your behalf.

Authorized Representative's Name

Mailing Address

City

State

Zip Code

Area Code and Phone Number

Email Address

Mail to:

Mediation/Fair Hearing Office
c/o Department of Rehabilitation
Legal Affairs
P. O. Box 944222
Sacramento, CA 94244-2220

Or fax to:

(916) 558-5861

Or email to:

Appealsinfo@dor.ca.gov