

APPEAL AGAINST ADMISSION DECISION

Please complete in **BLOCK LETTERS AND BLACK INK** or **TYPE**

**I/We wish to appeal against the decision of the Governors of _____
School not to offer my child a place at the school.**

1	Full name of your child								
2	Date of birth:	Date		Month		Year			
3	Title (please tick)	Mr		Mrs		Ms		Other	
	Full name of parent(s) or guardian(s):								
4	Relationship to child	Parent		Guardian		Other Please state			
5	Home address:								
		Postcode							
6	Home telephone number:								
7	Mobile telephone number:								
8	E mail address:								
9	Name of school offered/allocated:								
10	Does your child have a disability?	Yes		No		Tick appropriate box)			
11	I wish to attend my appeal in person	Yes		No					
	If no, do you wish the appeal to be heard using the information on this appeal form and accompanied papers?	Yes		No					
12	Name and capacity of other persons who will accompany you to the hearing.								
13	Please tell us if you have a disability and need assistance or have any other concerns regarding access.								
14	If you need an interpreter, please bring a friend/relation as we find that people you know make better translators.	Bringing friend/relative	Yes/No/ Not applicable	If school to provide interpreter. Which language?					
15	Does your child currently have a statement of Special Educational Needs?	Yes		No					
16	Are there any days of the week when you would not be able to attend a hearing?								
17	Are you happy to receive less than 14 days notice of your hearing?	Yes		No					

Office use only

Date Received

Ack sent E / P

