Department of Corrections
WASHINGTON STATE

LOG ID NUMBER

LEVEL II RESOLUTION RESPONSE

Last name	First	Middle	DOC number

Facility/office:	Unit/cell:

PART A – INITIAL CONCERN Action date: Date due:

My concern is (who and/or what):

Location:	Date of incident:	Time:

Witness(es):

Description:

Suggested remedy:

Requestor's signature _____ Date _____

Resolution Specialist _____ Signature _____ Date _____

PART B – LEVEL II RESPONSE

Superintendent/Health Services Administrator/
Reentry Center CCS/Field Administrator/designee _____ Signature _____ Date _____

You may appeal this response by submitting a written appeal to the Resolution Specialist within 5 working days from date this response was received.

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Resolution Program Manager **COPY** - Resolution Specialist, Individual