LEVEL II RESOLUTION RESPONSE

<table>
<thead>
<tr>
<th>Last name</th>
<th>First</th>
<th>Middle</th>
<th>DOC number</th>
</tr>
</thead>
</table>

Facility/office:  
Unit/cell:  

**PART A – INITIAL CONCERN**  
Action date:  
Date due:  

My concern is (who and/or what):  

<table>
<thead>
<tr>
<th>Location:</th>
<th>Date of incident:</th>
<th>Time:</th>
</tr>
</thead>
</table>

Witness(es):  
Description:  

Suggested remedy:  

<table>
<thead>
<tr>
<th>Requestor’s signature</th>
<th>Date</th>
</tr>
</thead>
</table>

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:  
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