

 Mashantucket Pequot Tribal Nation <i>Tribal Court</i>	MASHANTUCKET PEQUOT TRIBAL COURT <u>Notice of Appeal of</u> <u>DISABILITY REVIEW BOARD</u> <u>Final Decision</u> (Pursuant to 36 M.P.T.L. ch. 1, § 9, the Mashantucket Pequot Tribal Disability Law)	DO NOT WRITE IN THIS SPACE Docket No.: MPTC-CV-AA-_____ - _____
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PETITIONER'S NAME _____

ADDRESS: *(STREET AND/OR P.O. BOX)* _____

CITY _____	STATE _____	ZIP _____
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TELEPHONE NUMBER: (____) _____ - _____	ADDITIONAL PHONE / CELL / FAX NUMBERS: <i>(OPTIONAL)</i>
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MEMBER OF THE MASHANTUCKET PEQUOT TRIBE: <i>(CHECK AS APPLICABLE)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF BIRTH: _____
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PARTICIPANT IN ELDERS FINANCIAL ASSISTANCE PROGRAM: <i>(CHECK AS APPLICABLE)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	REGISTERED WITH MPTN TRIBAL HEALTH SERVICES: <i>(CHECK AS APPLICABLE)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO
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DATE ON WHICH YOU RECEIVED DISABILITY REVIEW BOARD DECISION: _____

DATE OF DISABILITY REVIEW BOARD DECISION: _____

The above-named Petitioner hereby appeals from the Disability Review Board's Final Decision referenced above:

SIGNATURE _____ **DATE** _____

FOR COURT USE ONLY		
Date Notice Sent by Certified Mail, Return Receipt Requested:		Filing Date:
Certified Mail Receipt No.:		
Date Return Receipt Received:		