

**Nebraska Health Care Learning Center
Grievance/Appeal Form**

Name (Last) _____ (First) _____ (MI) _____
Address _____
City _____ State _____ Zip _____
Phone (Day) _____ (Evening) _____

Description of the Problem _____

Remedy Requested _____

Does the student desire to appear in person at the hearing? Yes No

File form with
Director of LTCWIN
3900 NW 12th Street, Suite 100
Lincoln, NE 68521
Fax: (402) 475-6289

Office Use Only Received _____ Filed By _____ Action _____
