UNIVERSITY POLICE
Illinois State University

UNIVERSITY SMOKING VIOLATION APPEAL FORM

DATE SUBMITTED:_____ INCIDENT #:_____

ID# (UID, Driver's License, or State ID):_____

NAME:_____

STREET ADDRESS: _____ APT #:_____

CITY: _____ STATE: _____ ZIP:_____

PHONE #:_____ EMAIL ADDRESS: _____

IMPORTANT: THE WRITTEN STATEMENT THAT YOU PROVIDE ON THIS FORM ALONG WITH ANY ADDITIONAL INFORMATION SUBMITTED WILL BE CONSIDERED BY THE APPEAL OFFICER. YOU WILL NOT BE ALLOWED TOAPPEAR IN PERSON SO PLEASE ENSURE YOUR WRITTEN STATEMENT IS COMPLETE. (CONTINUE ON THE BACK OF THE FORM IF NECESSARY). PLEASE PROVIDE A CONTACT NUMBER SO THAT YOU MAY BE REACHED IF THE APPEAL OFFICER HAS ANY QUESTIONS. A FINAL DETERMINATION WILL BE SENT TO YOU, EXPLAINING THE OUTCOME OF THE APPEAL. DETERMINATION NOTIFICATIONS AND/OR REFUNDS ARE MAILED TO THE ADDRESS YOU INDICATE ON THIS FORM SO PLEASE ENSURE THIS INFORMATION IS ACCURATE AND COMPLETE.

I AM APPEALING THIS CITATION FOR VIOLATION OF THE SMOKE FREE CAMPUS ACT FOR THE FOLLOWING REASONS:

I AFFIRM THAT THE ABOVE STATEMENTS ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____

SIGNATURE DATE

THIS APPEAL FORM MUST BE RETURNED TO THE **ILLINOIS STATE UNIVERSITY POLICE DEPARTMENT, CAMPUS BOX 9240, NORMAL, IL 61790-9240** WITHIN SEVEN (7) DAYS OF VIOLATION DATE. NOTE: THIS MUST BE MAILED SEPARATE FROM PAYMENT. IF THE APPEAL IS GRANTED, PAYMENT WILL BE REFUNDED TO THE ADDRESS ABOVE.