STATE OF MISSOURI
FAMILY SUPPORT DIVISION

WITHDRAWAL OF WAIVER OF ADMINISTRATIVE HEARING DISQUALIFICATION CONSENT AGREEMENT

NAME OF INDIVIDUAL			
MAILING ADDRESS (NUMBER, STREET, P O BOX)			
CITY, STATE, ZIP CODE			
INDIVIDUAL DCN	SCN	DCN (HEAD OF HOUSEHOLD, IF DIFFERENT)	COUNTY OFFICE
HEARING OFFICER / INVESTIGATOR		ADDRESS	

I wish to withdraw my waiver of the Administrative Disqualification Hearing. I understand that the hearing will be conducted as if I had not signed the waiver.

SIGNATURE	DATE

TO WITHDRAW YOUR WAIVER OF ADMINISTRATIVE HEARING DISQUALIFICATION CONSENT AGREEMENT, YOU MUST SIGN AND RETURN THIS FORM TO THE COUNTY FSD OFFICE WITHIN FIVE (5) DAYS OF THE DATE YOU SIGNED THE WAIVER OF ADMINISTRATIVE HEARING DISQUALIFICATION CONSENT AGREEMENT.