HEARING APPEARANCE FORM

Hearing Date:

Hearing Location:

RETURN FORM TO THE HEARINGS ADVISOR BY

Hearings Advisor
Auckland Council
Democracy Services – Hearings Unit
Private Bag 92300
AUCKLAND 1142

Phone No:

Email:

NAME:		
PHONE NO:		
AGENT'S NAME:		
AGENT'S PHONE NO:		
Do you intend to speak at the Hearing?	**Yes**	**No**
Time required to speak to your evidence	**hours**	**min**
Will you do a digital presentation?	**Yes**	**No**
Do you require a Te Reo Translator?	**Yes**	**No**
Do you require a New Zealand Sign Language interpreter?	**Yes**	**No**
Names of Witnesses to be called:		
Name of person completing form:	**Date:**	