

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
Comments / Names of Witnesses to be called:		
Name of person completing form:	Date:	