

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: