

Organization Name					
Address (Head Office)					
Appellant	Department		Tel.		
	Name/Position		Fax.		
Appeal/ Complaint					
Appellant:	(Signature) D	ate:			
ISMS Scheme Manager Decision			Verified by Appellant		
		□ Satisfied □ Not			
			by (Signature)		
		Ī			
			date :		
By:(Signatu	are) Date of Response :				
Appeal Committee Decision (If needed)			Verified by Appellant		
Date of Appeal: Date of Meeting:		-	□ Satisfi	ed	🗆 Not
		F	by		(Signature)
Chairperson	(Signature) Date of Response:		Date:		

* NOTE: Any relevant information can be attached.