



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 2, 2026

Violet Bettig
Guardian Angel Homes LLC
725 N. Dettman Rd.
Jackson, MI 49201

RE: License #: AS380389381
Investigation #: 2026A0007011
Saint Gabriel

Dear Violet Bettig:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

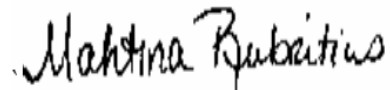
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A six-month provisional license is recommended due to the quality of care violations cited. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

A handwritten signature in black ink that reads "Mahtina Rubritius". The signature is written in a cursive style with a small dot at the end.

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

**THIS REPORT CONTAINS QUOTED DEROGATORY LANGUAGE AND QUOTED
PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS380389381
Investigation #:	2026A0007011
Complaint Receipt Date:	01/07/2026
Investigation Initiation Date:	01/07/2026
Report Due Date:	03/08/2026
Licensee Name:	Guardian Angel Homes LLC
Licensee Address:	725 N. Dettman Rd. Jackson, MI 49201
Licensee Telephone #:	(269) 363-1670
Administrator:	Violet Bettig
Licensee Designee:	Violet Bettig
Name of Facility:	Saint Gabriel
Facility Address:	1038 Woodbridge Jackson, MI 49202
Facility Telephone #:	(517) 914-0584
Original Issuance Date:	02/23/2018
License Status:	REGULAR
Effective Date:	08/07/2024
Expiration Date:	08/06/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED
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II. ALLEGATION(S)

	Violation Established?
On December 23, 2025, Resident A was observed to have a black eye, which was reportedly caused by a direct care staff member. The direct care member has been terminated.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/07/2026	Special Investigation Intake - 2026A0007011
01/07/2026	Special Investigation Initiated – Letter -Email to Aubrey Lee, APS Worker.
01/07/2026	Contact - Telephone call received from Aubrey Lee, APS Worker.
01/08/2026	Contact - Document Received - Picture of injury to Resident A's eye.
01/08/2026	Inspection Completed On-site - Unannounced - Face to face contact with John Miatech, DCW, Resident A, and Resident C.
01/09/2026	APS Referral Received.
01/09/2026	Contact - Telephone call made to and email to Aubrey Lee, APS Worker.
01/09/2026	Contact - Telephone call received from Ashlee Griffes, Office of Recipient Rights. Discussion.
02/24/2026	Inspection Completed On-site - Face to face contact with John Miatech, DCW, Resident A, Jasmine Smith, Home Manager, and Aubrey Lee, APS Worker.
02/25/2026	Contact - Face to Face with Aubrey Lee, APS Worker.
02/25/2026	Contact - Telephone call made - Victor Edwards, message left. I requested a return phone call.

02/26/2026	Contact - Telephone call made to Jasmine Smith, Home Manager. Documentation requested.
02/26/2026	Contact - Document Received - Copy of staff schedule and BTP for Resident A.
02/26/2026	Contact - Telephone call made to Victor Edwards, no answer.
02/27/2026	Exit Conference conducted with Violet Bettig, Licensee Designee.

ALLEGATION: On December 23, 2025, Resident A was observed to have a black eye, which was reportedly caused by a direct care staff member. The direct care member has been terminated.

INVESTIGATION:

As a part of this investigation, the following information was gathered from the written complaint: Resident A (44) is his own guardian, and he resides at St. Gabriel's AFC Home. Resident A has schizoaffective disorder, autism spectrum disorder, and a moderate-intellectual disability. On December 22, 2025, Victor Edwards was the direct care staff member who worked in the home with Resident A. Resident A made an aggressive behavior that he directed at Victor Edwards. Victor Edwards responded by punching Resident A in one of his eyes, causing a black eye, though most of the bruising is gone as of 1/5/2025. At the time of the injury, staff filed an incident report, and the home manager and Resident A's parents were informed of what happened. Resident A was offered medical attention, but he declined. Victor Edwards was terminated from the home.

On January 7, 2026, I spoke with Aubrey Lee, APS Worker, who informed me that he still had an open case for Resident A. I provided him with the updated information, and he informed me that he would stop by and see Resident A that day.

On January 8, 2026, I observed a picture of Resident A's right eye. The photo had been taken when the injury was discovered in December of 2025. There was bruising below his eyebrow and underneath his right eye.

On this same date, I spoke with Aubrey Lee, who informed me that he made face to face contact with Resident A and the bruising was no longer there. He also informed me that Resident B witnessed the incident, and Portia Ryan, Direct Care Staff, observed the bruising on Resident A's face after the incident occurred.

On January 8, 2026, I conducted an unannounced on-site investigation and made face to face contact with John Miatech, DCW, Resident A, and Resident C. John

Miatech informed me that he was not at the facility when the incident occurred but as soon as he observed the bruising, he notified Jasmine Smith, DCW, right away. It should be noted that Jasmine Smith also has the role of home manager. According to John Miatech, Resident A seemed to be confused about what happened and when they tried to gather additional information, he would change the subject. John Miatech informed me that Victor [Edwards] was working at that time and he kept calling the police because Resident A was attacking him. John Miatech informed me that the bruising around Resident A's eye was now gone.

While at the facility, I observed Resident A who was asleep. I did not observe any bruises on his face. I also observed Resident C who was sitting in the living room on the couch, and she appeared to be doing well.

On January 9, 2026, I spoke with Ashlee Griffes, ORR, who was also conducting a special investigation. She conducted a home visit on January 6, 2026, and did not observe Resident A to have any bruises on his face. While she was there, staff were snapping at each other. There was also a concern that Jasmine Smith was snapping at Resident B. During the home visit, Jasmine Smith turned to her, Ashlee Griffes, and stated, "You're not going to like this but..." then she (Jasmine Smith) said to Resident B "I don't give a fuck what Victor said!" Ashlee Griffes informed me that Resident B was saying that Victor [Edwards] was making a comment about his kids being his first priority. Jasmine Smith told Resident B to keep her kids name out his mouth. According to Ashlee Griffes, after the incident in which Victor Edwards hit Resident A, Jasmine Smith terminated him.

Ashlee Griffes informed me that there was also a concern that facility van was inoperable. In addition, at one point the oven did not work and Guardian B1 brought over a new oven.

On February 24, 2026, I made face to face contact with Aubrey Lee, APS Worker. He informed me that he still had an open case regarding Resident A; as his parents had filed for guardianship, and he was waiting for the guardianship to be finalized. Regarding this investigation, he informed me that he had previously interviewed Resident A and he did not provide much information regarding the incident. He also informed me that he interviewed Resident B, who was in the home when the incident occurred. Resident B stated he saw that Victor Edwards had hit Resident A.

On February 24, 2026, Aubrey Lee, APS Worker, and I conducted an unannounced on-site investigation and made face to face contact with John Miatech, DCW, Resident A, and Jasmine Smith, Home Manager. Jasmine Smith informed us that Lifeways had sent a letter in December 2025 regarding the special certification contract and that the contract would end effective, March 19, 2026. Jasmine Smith informed me that Violet Bettig, Licensee Designee, had not informed the staff about this, so she had to let them know what was going on in preparation of the changes. According to Jasmine Smith, Resident B was away touring and staying at a different facility, Resident C had already been relocated, and Resident A's parents, who were

now his guardians, were also looking for a different placement. According to Jasmine Smith, the guardianship for Resident A was approved last week (week of 2/16/26), but she did not have the final paperwork.

I interviewed Jasmine Smith in the kitchen. Regarding the incident, she stated that several staff, including herself, were off work with the flu and Victor Edwards was working alone on the day in question (12/21/25). Jasmine Smith informed me that Resident A required 1:1 supervision and there were three residents (Resident A, Resident B, and Resident C) in the facility that day and Victor Edwards could not get Resident A to calm down. Regarding the injury, Victor Edwards stated that Resident A ran into the door, but she found out that he punched Resident A in the eye. It was also reported to her that Victor Edwards told Employee #1 that he punched Resident A, but he was coming up with another excuse. I requested a copy of the incident report (IR) and Jasmine Smith stated that they no longer keep paper copies of IR's, but the information had been uploaded into the Lifeways tracking system.

Jasmine Smith also informed me that on a different date (specific date not stated), Ashley Griffes, ORR was at the facility talking to Resident B, and he was telling her about things going on in the facility. Jasmine Smith stated that she made it very clear that this was the first time that she had heard the information that Resident B was reporting. It was noted that Victor Edwards is the father to her (Jasmine Smith's) granddaughter. According to Jasmine Smith, Resident B had said something referring to her granddaughter. Resident B, using slang, also said something about what Victor Edwards said. I inquired if she used any curse words or profanity in front of Resident B, and she stated that she may have. I then asked if she specifically stated, "I don't give a fuck what Victor [Edwards] said," and she confirmed that she stated that because of what Resident B said that Victor Edwards said. According to Jasmine Smith, Resident B was repeating something he heard Victor Edwards say. Jasmine Smith agreed with me that it was not appropriate to speak in that manner in front of any residents. During the interview, Jasmine Smith expressed her frustrations and described being overwhelmed with the issues in the facility. She stated that she really cared about the residents and had invested ten years working in the facility, caring for them, without much needed support. She stated that when the facility van broke down, she rented a vehicle, with her own money, so that they could get the residents to their appointments. The van was recently fixed and returned to the home; but there was a time when it was in the shop, Violet Bettig had the keys, and it was unavailable. She also expressed concerns regarding the licensee not being there, the lack of communication, and the responsibility falling on her. Jasmine Smith was visibly upset while describing her concerns.

While at the facility, Aubrey Lee and I attempted to interview Resident A. Resident A did not provide any information to confirm or refute the allegations.

As a part of this investigation, I reviewed the *Office of Recipient Rights Report of Investigative Findings*. It was noted that ORR reviewed the incident report authored by Jasmine Smith on December 22, 2025. It was noted that Jasmine Smith was not

home when the situation occurred, and she and other staff members were sick with the flu. When staff arrived the following day, they noticed that [Resident A] had a mark on his eye. [Resident A] told staff that he [Resident A] attacked Victor [Edwards] and he punched him. The staff member contacted her (Jasmine Smith), she went in the following day and observed the resident for herself. It was also noted in the investigation that ORR observed Resident A, and his eye was no longer swollen or bruised. Resident A could not recall the incident. ORR also interviewed Jasmine Smith, Case Manager #1, Relative A1, Resident B, Portia Ryan, DCW, Doctor #1, and Matt Owens, Lifeways Contract Procurement Director.

According to the ORR report, Resident B was interviewed and he informed ORR that he was in the kitchen eating a snack, and he could see Resident A, who was sitting in the living room. According to Resident B, Resident A was “in a mood,” and he attacked Victor Edwards and Victor Edwards punched Resident A in the eye. Resident B stated that Victor Edwards said that he “doesn’t give a fuck” about his job or the recipients (residents). Resident B also stated that Victor Edwards said that he was going to beat up the home manager, Jasmine Smith. Resident B reported that Victor Edwards said he only cares about his daughter. Resident B was then interrupted by Jasmine Smith, as she looked at the ORR Officer and said, “You’re not going to like this,” then she proceeded and told Resident B, “I don’t give a fuck what Victor said. Keep my daughter’s name out of your mouth.” The ORR Officer stopped Jasmine Smith from continuing to swear at Resident B. Lifeways Contracts Department was notified regarding this repeated behavior. During the interview with Portia Ryan, DCW, she informed that she arrived at work after Victor Edwards (on 12/22/25), and Resident A had a black eye. Portia Ryan contacted Jasmine Smith, who terminated Victor Edwards. Portia Ryan, DCW, did not seek medical treatment for Resident A, as she stated she was not instructed to and could not leave the other residents alone in the facility. Doctor #1 was interviewed by ORR, and part of what he reported is as follows: “The black eye is a result of serious physical harm, and the failure to obtain medical evaluation after the incident could contribute to serious physical harm. A ‘black eye’ represents peri-orbital bleeding (bleeding under the skin, in the region around the eye/orbit)...it is possible to develop an embolism (blood clot) within the brain, due to facial injury-especially if bones of the face are fractured...Additionally, the intensity and location of force that results in a black eye could also render significant and potentially permanent damage to the eye itself- these type of injuries can result in impaired vision, ocular pain, and even blindness. Therefore an exam is indicated following a traumatic event such as that which took place.” ORR also attempted to contact Victor Edwards by phone on at least three different dates. He was also sent a letter, and he had not responded upon completion of the investigation. It was also documented in the report that a *Notification to Discontinue Services* letter was reviewed. It was a formal notification that Lifeways would discontinue services with Guardian Angel Homes, LLC. The discontinuation of all services would conclude no later than sixty days on or before March 21, 2026. This would depend on the timeframes for transitioning the residents out of the home.

ORR concluded that there was a preponderance of the evidence and the following violations were established: 7221 – Abuse Class I, 72252 – Neglect Class I Failure to Report, and 7555 – Retaliation/Harassment.

On February 25, 2026, I made face to face contact with Aubrey Lee, APS Worker. He informed me that he left a message for Victor Edwards but had not heard back from him. I also attempted to contact Victor Edwards without success.

A review of the facility licensing file reflects that there have been multiple investigations at this facility, and while several of them were not supported by a preponderance of the evidence, there has been a pattern of complaints regarding quality of care and physical plant concerns. Specifically, it was noted in SIR #2024A0007007 (dated 2/14/2024), that Resident A had an injury to his finger and the direct care staff reported that he had to restrain Resident A by holding down his wrists but denied ever grabbing him by the wrists. The direct care staff denied harming Resident A. The direct care staff reported that he never received any kind of physical management training. The following rule, Rule 400.14307 (2) regarding *Residents Behavior Interventions* was substantiated. The licensee submitted a written corrective action plan (CAP) to address the established violation, which included that case management for Resident A would be notified that the Person-Centered Plan needed to be updated and provide guidance to staff when utilizing physical interventions. In addition, the licensee included in the CAP that all direct care staff had either received or were scheduled to complete Physical Management and Crisis Intervention Training through Lifeways. The licensee submitted the Statement of Correction, dated April 9, 2024, and she documented that Resident A's Behavior Treatment Plan had been updated by a licensed BTP Coordinator, to include specialized interventions, and that the direct care staff had completed the Intervention and Technique training. ORR substantiated the allegations, Abuse, Class I. The rules cited in SIR #2024A0007007 were prior to the promulgation of the current rule set which became effective November 3, 2025.

On February 27, 2026, I conducted the exit conference with Violet Bettig, Licensee Designee. We discussed the investigation and my recommendations. Violet Bettig stated she was having some health issues and that the stress was not helping; she described her health complications and problems in her own home. She stated she had received some calls regarding Jasmine Smith's behavior, and she was disappointed. She voiced concerns about Jasmine Smith not following through on things she was expected to handle. Violet Bettig discussed changing management in the facility. I reminded Violet Bettig that this was her business, she was the licensee designee and ultimately responsible. She also discussed the challenges with the van and the complications with getting it fixed. She informed me that the contract with Lifeways would end in March and that she planned to contact them to see if they could work something out. She has also been seeking to get contracts from other areas of the state and stated she has been getting calls about potential placements. Regarding the incident involving Resident A, she stated that there have been issues in the past where Resident B had stated he seen something and then they later find

out that he didn't witness the incident. She stated that Jasmine Smith hired Victor Edwards, and that it would no longer be acceptable to hire friends and family. Violet Bettig stated that once she was informed of the incident, she told Jasmine Smith that if the resident was saying the guy hit him, then he's gone. Violet Bettig stated that Jasmine Smith made sure he was gone that day. During the conversation, I discussed the recommendations and her options. I explained that if she (Violet Bettig) accepted the provisional license and if there were any more substantiated cases for quality of care, during the Provisional licensing period, that the next step would be revocation. We also discussed her closing the license, taking time to address her health issues, revamping the business and her submitting a new application for licensure. I informed her that I could not advise her either way but wanted to be sure that she understood the licensing procedures. Violet Bettig informed me that she would review the information and let me know how she would like to proceed.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based upon my investigation, which consisted of unannounced on-site investigations, interviews with staff, review of pertinent documents, interviews with ORR and coordination with APS, it's concluded that there is a 51% preponderance of the evidence to support the allegations that Resident A and Resident B were not treated with dignity and respect, and their protection and safety were not attended to at all times. REPEAT VIOLATION – Please see SIR#2024A0007022 - CAP Approved 6/24/2024 for additional information. Note: The rules were cited in the repeat violation SIR were prior to the promulgation of the new rules, which became effective on November 3, 2025.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the interview with Jasmine Smith, she stated that several staff, including herself, were off work sick with the flu and Victor Edwards was working alone at the facility (on 12/21/2025). Jasmine Smith informed me that Resident A required 1:1 supervision and there were three residents (Resident A, Resident B, and Resident C) in the facility that day.

I reviewed the staff schedule for 12/19/25 to 12/25/25, and it was noted that Victor Edwards was scheduled to work on 12/21/2025 from 9:00 a.m. to 9:00 p.m., and John Miatch was scheduled to work on this same date, from 9:00 a.m. to 5:00 p.m., and the next staff member was scheduled from 5:00 p.m. to 9:00 p.m. I spoke with Jasmine Smith who confirmed that John Miatch was one of the direct care staff who was out sick with the flu that day (12/21/2025).

A review of the *Behavior Treatment Plan* for Resident A reflected that Resident A has a history of severe physical aggression towards staff, family, and community members. He requires 24/7 supervision to ensure his overall health and safety. It was also noted that dedicated staff are to be within arms-length of Resident A.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	<p>(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following:</p> <p>(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.</p> <p>(b) 12 residents for small group and family homes.</p>
ANALYSIS:	Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that there was not sufficient direct care staff on duty, at all times, for the supervision, personal care, and protection that Resident A required; specifically having a direct care staff member within arms-length of Resident A at all times. It would not be possible for one direct care staff member to achieve this level of supervision while also caring for two other residents.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On February 24, 2026, I reviewed the employee file for Victor Edwards. His dates of employment were 11/7/25 (rehire date) to 12/23/25 (termination date). It was noted that he had received in-house direct care staff training; however, there was no documentation that he had also received direct care staff training for working in a

home with a Special Certification or Recipient Rights training. There was no documentation contained within his employee file to demonstrate that the Workforce Background Check clearance had been completed and documenting that he was eligible to work in adult foster care homes; however, there was (background check) paperwork, dated 1/6/2026, documenting that he was no longer working at the facility.

APPLICABLE RULE	
R 400.707	Staff training.
	<p>(1) Staff who work with residents shall have successfully completed training that provides basic concepts required in providing specialized dependent care before working independently. Staff shall show the ability to comprehend and be competent to deliver each resident's individual plan of service as written. Training must include all of the following before working independently:</p> <p>(a) An introduction to community residential services and the role of direct care staff.</p> <p>(b) Understanding and carrying out individual plans of service for residents.</p> <p>(c) An introduction to the special needs of residents that have developmental disabilities or have been diagnosed as having a mental illness and is specific to the needs of residents to be served by the facility.</p> <p>(d) Protecting and respecting the rights of residents in accordance with chapter 7 of the mental health code, 1974 PA 258, MCL 330.1700 to 330.1758, including providing resident orientation to written facility policies and procedures.</p> <p>(e) Non-aversive techniques for prevention and treatment of challenging behavior of residents in accordance with an individual plan of service.</p>
ANALYSIS:	Based upon my investigation, which consisted of an interview with Jasmine Smith, Home Manager, and review of the employee file for Victor Edwards, it's concluded that there is a preponderance of the evidence to support the allegations that Victor Edwards did not complete all the required training before working independently in the facility.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On February 24, 2026, I reviewed the employee file for Victor Edwards. There was no documentation contained within his employee file to demonstrate that the Workforce Background Check clearance had been completed and documenting that he was eligible to work in adult foster care homes; however, there was (background check) paperwork, dated 1/6/2026, documenting that he was no longer working at the facility.

On February 26, 2026, I reviewed the Michigan Workforce Background Check website, and it was noted that the application for Victor Edwards was withdrawn in May of 2022 (when he was first hired) and again on January 6, 2026 (hire date in November of 2025).

APPLICABLE RULE	
MCL 400.734b	Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or

	covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based upon my investigation, which consisted of a review of the Michigan Workforce Background Check website and the employee file for Victor Edwards, it's concluded that there was no documentation contained within his employee file and available for review, to demonstrate that he was eligible to work in an adult foster care home with vulnerable adults.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an approved written corrective action plan, it's recommended that a six-month (6) provisional license be issued due to the quality-of-care violations cited. If you do not contest the issuance of a provisional license, you must indicate so in writing. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled.

Mahtina Rubritius

02/26/2026

Mahtina Rubritius
Licensing Consultant

Date

Approved By:

Dawn Timm

02/27/2026

Dawn N. Timm
Area Manager

Date