

Case Number: \_\_\_\_\_

Employee: \_\_\_\_\_

Date: \_\_\_\_\_

### APPEAL REQUEST FORM

If you decide to appeal this decision, read these instructions carefully. You must specify which procedure you request by checking one of the options listed below. Place this form on top of any materials you submit. Be sure to mail this form, along with any additional materials, to the appropriate address. **YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT THIS TIME.**

\_\_\_\_ ORAL HEARING

Depending on your geographical location, the issue involved in your case, the number of hearing requests in your area, and at the discretion of the hearing representative, we may expedite your appeal by providing you a telephone hearing or videoconference. **Please check here if you would prefer a telephone hearing.** \_\_\_\_

\_\_\_\_ REVIEW OF THE WRITTEN RECORD

For each of these options, you must submit this form within 30 calendar days of the date of the decision. You may also submit additional written evidence with your request. You must mail your request to:

Branch of Hearings and Review  
Office of Workers' Compensation Programs  
P. O. Box 37117  
Washington, DC 20013-71 17

\_\_\_\_ RECONSIDERATION:

Submit your request within 1 calendar year of the date of the decision. You must state the grounds upon which reconsideration is being requested . Your request must also include relevant new evidence or legal argument not previously made. Mail your request to:

DOL DFEC Central Mailroom  
P. O. Box 8300  
London, KY 40742

\_\_\_\_ ECAB APPEAL:

Submit this form within 180 calendar days of the date of the decision. No additional evidence after the date of OWCP's decision will be reviewed . To expedite the processing of your ECAB appeal, you may include a completed copy of the AB 1 form used by ECAB to docket appeals available on the Department of Labor Web Site at [www.dol.gov/ecab](http://www.dol.gov/ecab). You must mail your request to:

Employees' Compensation Appeals Board  
200 Constitution Avenue NW, Room S-5220  
Washington, DC 20210

SIGNATURE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_ DECISION DATE: \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_