ECAB Docket Number: _____
(For Official Use Only)

U.S. DEPARTMENT OF LABOR
EMPLOYEES' COMPENSATION APPEALS BOARD
APPLICATION FOR REVIEW (AB-1) FORM

PLEASE TYPE OR PRINT APPLICATION

1. Name of Appellant: _____
(First) (Middle) (Last)

1a. Name of deceased employee, if applicable: _____

2. Date of OWCP Decision(s) Being Appealed: _____

NOTICE
YOUR APPEAL WILL BE SUBJECT TO DISMISSAL UNLESS YOU PROVIDE THE OWCP DECISION DATE YOU ARE APPEALING.

PLEASE NOTE: An Application for Review must be filed within 1 year of the date of the OWCP Decision(s) being appealed. No new evidence can be submitted with an appeal.

3. Appellant's Street Address: _____

City, State, and Zip Code: _____

4. Appellant's Telephone Number (s): (_____) _____
(Area Code)

5. OWCP Case File Number _____

6. Is Oral Argument requested? _____ Yes _____ No

PLEASE NOTE: **If requested, oral arguments are held only in Washington, DC. The Board does not pay for any travel or incidental expenses related to attending oral argument. No new evidence can be submitted.**

7. Briefly state the specific reasons for your disagreement with the Decision of the OWCP: (Use additional sheets if needed.)

_____

_____

_____

8. Appellant's Signature: _____(Date)_____

9. YOU DO NOT HAVE TO HAVE A REPRESENTATIVE IN ORDER TO PURSUE YOUR APPEAL**. IF A REPRESENTATIVE IS DESIGNATED, THEN HE OR SHE MUST SIGN THIS FORM CONSENTING TO REPRESENT YOU.** My authorized representative for the purpose of this appeal is:

Representative's Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Telephone Number: _____ (_____) _____
(Area Code)

10. Representative's Signature: _____ (Date)_____

If you have any questions concerning this form, call the Employees' Compensation Appeals Board at (202) 693-6360 or send a facsimile (fax) to the Board at (202) 693-6367.

Enclosures