

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.**

An Application for Review must be filed within the applicable time parameters as determined by 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): _____

5. OWCP Case File (Claim) Number: _____

6. Is Oral Argument requested? Yes No If so, you must explain the need for Oral Argument:

**PLEASE NOTE: 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: (____) _____

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.

Attachments