APPEAL REQUEST FORM

Instructions: Complete the appeal request in blue or black ink. Please provide as much information as possible including details from your determination or decision to assist with the appeal process.

Who is the appealing party? ☐ **Claimant** ☐ **Employer**	**GDOL STAFF USE ONLY**
Date Submitted:	
CLAIMANT INFORMATION	**Date Received:**
Claimant's SSN:	**Claims Examiner Determination Release Date:**
Claimant's Name:	**Hearing Officer Decision Release Date:**

Claimant's Address:		**Apt.**
City:	**State:**	**Zip:**
If there is an ALTERNATE MAILING ADDRESS for this appeal, list it below.		
Street:		**Apt.**
City:	**State:**	**Zip:**
Primary Phone Number:	**Alternate Phone Number:**	
E-mail Address:		

EMPLOYER INFORMATION

Employer/Business Name:		**GDOL Account Number:**
Employer Address:		
City:	**State:**	**Zip:**
Primary Phone Number:	**Alternate Phone Number:**	
E-mail Address:		

OTHER PARTICIPANT INFORMATION

If you are not the claimant or the employer, what is your involvement in this appeal?
☐ **Claimant Representative** ☐ **Employer Representative** ☐ **Other, please specify:**

First Name:	**Last Name:**	**Job Title:**
Address:		
Street:		
City :	**State:**	**Zip:**
Primary Phone Number:	**Alternate Phone Number:**	
E-mail Address:		

APPEAL INFORMATION

What type of decision is being appealed?

☐ **Benefits Determination** ☐ **Appeals Tribunal Decision** ☐ **Board of Review Decision**
☐ **Claims Examiner Determination** ☐ **Ruling of Administrative Hearing Officer** ☐ **Overpayment Determination**

To whom are you appealing? ☐ **Appeals Tribunal** ☐ **Board of Review**	
Mail Date of Decision/Determination Being Appealed (as shown on your determination/decision (MM/DD/YYYY):	
Was a hearing previously scheduled with the Appeals Tribunal? ☐ **Yes** ☐ **No**	**If YES, what is the docket number?**
If YES, did you participate in the previous hearing? ☐ **Yes** ☐ **No**	

CONTINUE ON REVERSE SIDE

APPEAL REQUEST FORM

REASON FOR APPEAL

Describe in the space provided below, the reason for appeal. If you failed to participate in a previous hearing, include the reason for failure to participate.

I disagree with the decision because:

ACCOMMODATIONS

Do you need a language interpreter for your hearing? ☐ **Yes** ☐ **No** (If needed, an interpreter will be provided at no cost.)	**IF YES, what language?**

The Georgia Department of Labor provides accommodations for people with disabilities to participate in appeal hearings. If such accommodations are needed, please describe below.

IMPORTANT NOTICE

You **must** continue claiming (certifying for) benefits and submitting work search reports, if required, for each week you wish to receive benefits, either by Internet, by telephone, or in person. Failure to do so may result in a denial of your benefits, even if you win your appeal.

ACKNOWLEDGEMENT

By witness of my signature below, I acknowledge I have been advised and understand I **must** claim benefits and submit work search reports, if required, for each week I wish to receive benefits as stated above. I further attest the information I have provided is true and complete to the best of my knowledge and belief.

Signature	**Date**