ECAB Docket No. _____
Official Use Only

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 180 days following the date of the OWCP Decision(s) being appealed. If your appeal is not timely filed, you must attach a statement with supporting documentation establishing compelling circumstances which prevented timely filing.

3. **Appellant's Street Address**: _____

City, State, and Zip Code: _____

4. **Appellant's Telephone Number(s)**: _____

5. **OWCP Case File (Claim) Number: _____**

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

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7. **Is Oral Argument requested**? ☐ Yes ☐ No

If yes, your request will be granted or denied in the Board's discretion pursuant to the Board's *Rules of Procedure* (Code of Federal Regulations 20 C.F.R. § 501.5 (rev. 2008)). You must state the specific issue(s) to be argued and state in detail the specific reasons that an oral argument is necessary as part of your appeal. The issues and supporting statement need not be long, but they should be as clear and specific as possible. Should your request for oral argument be denied, the appeal will be decided on the record. (Use additional sheets if necessary.)

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PLEASE NOTE: By requesting Oral Argument you are confirming that you will appear at the date and time scheduled if the oral argument is granted. The Board does not pay for travel, or any other expenses, related to attending oral argument. **Evidence that was not in the case record at the time of the decision(s) appealed to ECAB cannot be submitted to the Board at oral argument.**

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 1-(866) 487-2365 or send a facsimile (fax) to the Board at (202) 513-6833. To mail the form, address it to the Employees' Compensation Appeals Board, Office of the Clerk, U.S. Department of Labor, 200 Constitution Avenue, N.W. Room S5220, Washington, D.C. 20210.

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