

CLAIMANT'S REQUEST TO RECONSIDER

DOCKET NO.: _____

Claimant's Name
Address
City, State, ZIP
Telephone/Fax

In the space provided below, briefly state why your appeal should be reconsidered:

Please Sign and Date Here:

Signature

Date

DO NOT ENTER INFORMATION BELOW

:

FOR TRIBUNAL USE ONLY

(Affix Date Stamp Here)

Date of Decision:

Hearing Judge:

Date Decision was entered:

Date Decision was mailed:

Is Request Timely?

☐ Yes

☐ No

Request is ☐ GRANTED

Request is ☐ DENIED

☐ Not filed within 10-day reconsideration period

☐ Good cause not provided

☐ Other:

Administrative Law Judge:

Signature

Date

Please return the CLAIMANT'S REQUEST TO RECONSIDER to:
Nebraska Appeal Tribunal, P.O. Box 98941, Lincoln, NE 68509. You may also fax this to the Tribunal at (402) 471-1734