

**Virginia Employment Commission
First Level Appeals**

Name: _____

Address: _____

City & State: _____

Claimant ID #: _____ Telephone Number: _____

I wish to appeal a Deputy's decision: Issue ID #: _____

Benefit Year End (BYE) Date: _____

Overpayment Amount (if applicable): _____

The issue ID and BYE date of your claim are on the decision. If you do not provide the Issue ID and BYE Date on your form, it is not an appeal. We will forward the form to the Customer Call Center for reference if you call for information.

** If you are appealing a Partial Approval of Overpayment Waiver Request or a Denial of Overpayment Waiver Request, instead of the Issue ID you must provide the Overpayment Amount listed in the Claimant Information box.*

My reason for appealing the Deputy's decision:

Why I filed the appeal after the final date of appeal indicated on the Deputy's decision:

Do you need an interpreter? Yes _____ No _____

If your answer is yes, please provide the language: _____

Signature

Date

**Mail form to:
Virginia Employment Commission
First Level Appeals
P.O. Box 26441
Richmond, VA 23261-6441**

**Fax form to:
(804) 786-8492**

A-FLA-LOA