CLAIMANT'S REQUEST TO RECONSIDER	DOCKET NO.: _____
Claimant's Name Address City, State, ZIP Telephone/Fax	

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

Please Sign and Date Here:	_____ _____ Signature Date

DO NOT ENTER INFORMATION BELOW:		**FOR TRIBUNAL USE ONLY**
Date of Decision:		(Affix Date Stamp Here)
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 DECISION to:
Nebraska Appeal Tribunal, P.O. Box 94600, Lincoln, NE 68509-4600. You may also fax this to the Tribunal at (402) 471-1734