DIVISION OF EMPLOYMENT SECURITY

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

CLAIMANT REQUEST FOR APPEAL OF UNEMPLOYMENT INSURANCE DETERMINATION

Claimant's Name *(Print)*	Social Security Number

Date of Determination	Name of Employer

I appeal this determination. Brief statement explaining why: _____

Date	Signature

Mail to:
Division of Employment Security
Appeals Tribunal
P.O. Box 59
Jefferson City, MO 65104

Fax to:
573-751-1321

***IMPORTANT**: If needed, call 573-751-3913 for assistance in the translation and understanding of the information in this document.*

***¡IMPORTANTE!**: Si es necesario, llame al 573-751-3913 para asistencia en la traducción y entendimiento de la información en este documento.*

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