



Paid Leave Appeal Withdrawal Form

You must provide a written request to withdraw your request for an appeal. You may use this form to make your request. Please use one form per withdrawal request. Submitting an appeal withdrawal request is your choice and we will consider your appeal request closed after we receive this form. When completed, print this page and fax or mail it to the address listed below.

Your contact information		
Claim ID, Social Security Number, or ITIN:		
Name <i>(first and last):</i>		
Phone number:		
Email address:		
Current mailing address:		
City:	State:	Zip:
Appeal withdrawal information		
I, _____, confirm that it is my intent to withdraw the appeal I filed regarding a determination (benefit decision) by the Employment Security Department's Paid Family and Medical Leave program, effective immediately. Specifically, I appealed (briefly describe the nature of your appeal and/or date of decision):		
I verify that I have the knowledge and authority to withdraw this appeal. By completing this form and sending it to the Attorney General's Office, I understand that my appeal is withdrawn and closed and there will be no administrative hearing on this case.		
Print name:		
Signature:	Date:	
Mail or fax to: Employment Security Department, Paid Family and Medical Leave Care Center, PO Box 19020 • Olympia, WA 98507-0020 • Fax: 833-525-2273		

The Employment Security Department is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Language assistance services for limited English proficient individuals are available free of charge. Washington Relay Service: 711