Washington
Paid Family & Medical Leave
Employment Security Department

Paid Leave Appeal Request Form

You may use this form to appeal if you disagree with a decision you received from us. An appeal cannot be filed until a determination has been made. Please use one request form per decision you wish to appeal.
For instructions on filing an appeal, refer to the decision letter we sent you. You can read more about appeals in the Paid Family and Medical Leave Benefit Guide at paidleave.wa.gov/benefit-guide and on our website at paidleave.wa.gov. When completed, print this page and fax or mail it to the address listed below. ***Appeals must be filed within 30 days after the date of notification or mailing, whichever is earlier (RCW 50A.50.010).***

Your contact information

Claim ID, Social Security Number, or ITIN:		
Name *(first and last)***:**		
Phone number:		
Email address:		
Current mailing address:		
City:	**State:**	**Zip:**

Additional information

Do you need an interpreter?	**Yes**	**No**
If yes, please list your preferred language:		
Employer name:		**UBI#** *(if known)***:**
Please tell us why you disagree with the decision you are appealing.		
I certify under penalty of perjury that all the information included on this form is true and accurate and I understand that information involving the investigation and determination is to be made available to all interested parties (RCW 50A.40.020).		
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