DISTRICT OF COLUMBIA
Office of Administrative Hearings
One Judiciary Square
441 4th Street, NW, Suite 450N
Washington, DC 20001-2714
Tel: (202) 442-9094 · Fax: (202) 442-4789
Email: oah.filing@dc.gov

REQUEST FOR HEARING IN OFFICE OF PAID FAMILY LEAVE CASE

SECTION 1 – CONTACT INFORMATION

Name (please print): _____ Attorney/Representative (if any): _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Email: _____ Email: _____

SECTION 2 – Office of Paid Family Leave Determination/REASON FOR HEARING REQUEST

I am appealing and have attached a copy of the:

☐ **claims examiner determination** Date of determination: _____

☐ **determination on reconsideration (if any)** Date of determination: _____

Note: An appeal must be filed with OAH within sixty (60) calendar days after the date the claim determination or determination on reconsideration is issued.

PLEASE INDICATE THE TYPE OF DETERMINATION YOU ARE APPEALING.

☐ **Whether Claimant may receive benefits** under the Universal Paid Family Leave program

☐ **Weekly amount of benefits** payable to Claimant under the Universal Paid Family Leave program

☐ **Date payment shall begin** to Claimant for Universal Paid Family Leave benefits

☐ **Number of weeks** Claimant may receive Universal Paid Family Leave benefits

☐ **Provisional denial** of claim for Universal Paid Family Leave Benefits

Please include a brief description of why you disagree with the determination:

_____

_____

SECTION 3 – LANGUAGE ACCESS

Do you need language interpretation?

☐ YES ☐ NO

If YES, specify language: _____

SECTION 4 – ACCOMMODATIONS FOR DISABILITY

Do you need reasonable accommodation for disability at hearing?

☐ YES ☐ NO

If YES, please specify: _____

SECTION 5 – CLAIMANT SIGNATURE

Signature: _____ Date: _____