

Employment  
and Assistance  
Appeal Tribunal

Notice of Appeal

**Appellant Information:**

NAME	TELEPHONE No.	FILE No.
MAILING ADDRESS <i>(Information about your appeal will be sent to this address unless you tell us otherwise)</i>	POSTAL CODE	RECONSIDERATION No.

On what date did you receive the Ministry's reconsideration decision?

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Reasons For Appeal:**

Tell us why you disagree with the Ministry's reconsideration decision.

*(The Tribunal will obtain a copy of the record of the Ministry decision)*

**Type of Appeal Hearing:**

I would like my appeal hearing to be:

*(The Tribunal will attempt to accommodate your request)*

oral in person

oral by telephone

in writing

*(The Tribunal will contact the Ministry for consent for a written hearing)*

**Accommodation:**

Do you require accommodation due to a disability? Yes

No

If yes, please tell us what you need:

Your Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
Month/Day/Year

Within **7 business days** of receiving the Reconsideration Decision

Send the completed Notice of Appeal form to:

Employment and Assistance Appeal Tribunal  
PO Box 9994 Stn Prov Govt Victoria BC V8W 9R7

Toll Free Fax: 1-877-356-9687

Fax in Victoria: 250-356-9687

Questions? Call Toll Free:1-866-557-0035, or in Victoria: 250-356-6374

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act*, the *Employment and Assistance for Persons with Disabilities Act* and the *Child Care Subsidy Act*. The disclosure of this information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use and disclosure of this information, please contact the Employment and Assistance Appeal Tribunal.

EAAT001 (10/02/01)