

STATE OF ARKANSAS  
COURT OF APPEALS

PETITION FOR REVIEW TO THE  
ARKANSAS COURT OF APPEALS

1. Name/Company Name:

2. Social Security Number:

3. DL/ ID Number:

4. Address:

City:

State:

Zip Code:

5. Telephone Number:

( )

6. Board of Review Case Number:

7. Board of Review Mailing Date:

8. I appeal the decision of the Arkansas Board of Review for the following reason(s): (Attach copy of Board's Decision.)  
If you need additional space, please write "see attached" and attach a sheet of paper to this petition.

9. Sign, date, and mail or hand deliver this petition and a copy of the Arkansas Board of Review decision to the following:

(1) Arkansas Court of Appeals, 625 Marshall Street, Little Rock, Arkansas 72201

(2) Your Employer

\*Your Signature on this petition indicates you mailed copies to the parties listed above.

\*This petition must be postmarked within **thirty days** of the date of the Board of Review decision was mailed. The mailing date is listed on the last page of the Board's decision.

(10) Signature:

(11) Date:

Attorney Represented: YES:  NO:

If so, Attorney Bar #: \_\_\_\_\_

Attorney Name: \_\_\_\_\_

Does Attorney want to Brief? Yes:  NO: