STATE OF ARKANSAS COURT OF APPEALS	PETITION FOR REVIEW TO THE ARKANSAS COURT OF APPEALS

1. Name of Petitioner:	2. Social Security Number:	3. Driver's License Number/ID:

4. Address:	City:	State:	Zip Code:

5. Telephone Number: ( )	6. Board of Review Appeal Number:	7. Board of Review Mailing Date:

8. Are you Attorney represented?

Yes: ☐ No: ☐

Attorney Bar Number: _____

Attorney Name: _____

Employers Only

9. A $165.00 filing fee is required. Make check payable to Stacey Pectol, Clerk of the Court.
10. Are you attorney represented? Yes: ☐ No: ☐
11. Are you a Corporation? Yes: ☐ No: ☐

If you are a Corporation, it is **mandatory** that you have an attorney. If you are not represented by an attorney, your petition is subject to dismissal.

Attorney Bar Number: _____ Attorney Name: _____

12. Petitioner appeals the decision of the Arkansas Board of Review for the following reason(s): If you need additional space, please write "see attached" and attach your written response.

13. Petitioner shall sign, date, and mail or hand deliver this petition and a copy of the **Board of Review decision** to the following:

1. Arkansas Court of Appeals, 625 Marshall Street, Suite 130, Little Rock, Arkansas 72201
2. Your employer or employee

Your signature on this petition certifies that you mailed or delivered copies of the petition and attachments to the parties listed above.

This petition must be postmarked within thirty days of the Board of Review mailing date which is located on the last page of the decision.

(14) Signature:	(15) Date: