

REQUEST TO WITHDRAW A FAIR HEARING

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(877) 209-1134
Fax to: (518) 473-6735

**THIS FORM MUST BE COMPLETED BY THE APPELLANT OR AUTHORIZED REPRESENTATIVE ONLY.
CORRECT AND COMPLETE INFORMATION WILL PERMIT US TO PROMPTLY PROCESS YOUR REQUEST.**

Please print information clearly.

TODAY'S DATE: _____

FAIR HEARING NUMBER: _____ **CASE #:** _____

HEARING DATE: _____ **HEARING TIME:** _____

UPSTATE COUNTY: _____ **or NYC AGENCY:** _____

APPELLANT INFORMATION:

CASE NAME _____
(LAST) (FIRST) (MI)

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: _____

STREET ADDRESS: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: () _____ FAX NUMBER: () _____

REPRESENTATIVE INFORMATION:

NAME: _____

RELATIONSHIP TO APPELLANT: _____

REPRESENTATIVE ORGANIZATION: (IF APPLICABLE) _____

STREET ADDRESS: _____ SUITE/FLOOR/APT. # _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: () _____ EXTENSION: _____

**WHAT IS THE REASON YOU WISH TO WITHDRAW YOUR FAIR HEARING REQUEST?
(EXAMPLES: THE ISSUE WAS RESOLVED; YOU NO LONGER WISH TO PURSUE THE ISSUE, ETC.)**

SIGNATURE: _____ **DATE:** _____