(STATE AGENCY IDENTIFICATION)
REQUEST FOR ADDITIONAL INFORMATION

1. State Agency Address:	2. Federal Agency Name, 3 Digit Agency Code, and Address:

3. Local Office/Call Center ID: 4. Date of Request: 5. Effective Date: 6. Separation Date:

7. Claimant=s Name (Last, First, Middle Initial)	8. Social Security Number

9. State Agency Statement or Questions of Federal Agency:

10. Federal Agency Response:

11. Signature of Official _____ Title: _____

Print Name: _____ Telephone: (____)_____Date:____/____/_____

ETA-934 (Revised 1/2003)

OMB No.: 1205-0179 **OMB Expiration Date:** 10/31/2015 **Estimated Average Response Time:** 4 Minutes

O M B Burden Statement: These reporting instructions have been approved under the Paperwork reduction Act of 1995. Persons are not required to respond to this collection of information unless it displays a valid OMB control number. Public reporting burden for this collection of information includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Submission is required to obtain or retain benefits under SSA 303(a)(6). Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workforce Security, Room S-4231, 200 Constitution Ave., NW, Washington, DC, 20210.