Application for Appointment as Certified Workers' Compensation Mediator

THIS SPACE FOR COMMISSION USE ONLY

CC-FORM-926

☐ Initial Application
☐ Renewal

Please complete this form, sign under penalty of perjury and **return with a current resume** to the: Workers' Compensation Commission, Attention: Counselor Division, 1915 N. Stiles Avenue, Oklahoma City, OK 73105. **This application is for a 5-year term.** ***NOTE: Failure to provide all requested information may delay consideration of your application.***

ALL INFORMATION SUBMITTED TO THE COMMISSION MAY BE CONSIDERED A PUBLIC RECORD UNDER STATE LAW.
Direct all questions regarding disclosures to the Counselor Division.

Applicant Name:	Firm Name, if applicable:			Professional License Number (e.g. OBA Number)	
Mailing Address:	City	State	Zip Code	Name of Professional Licensing Body	
Office Address (Street Address):	City	State	Zip Code	Office Phone	Fax Number
Profession/Occupation	Cities In Which Available			E-Mail Address	

	Yes	No
1. Are you an active or senior member in good standing of the Oklahoma Bar Association?	☐	☐
2. Are you a non-attorney mediator certified pursuant to the requirements of the Dispute Resolution Act, 12 OS, § 1801 et seq.?	☐	☐
3. Have you worked in the area of workers' compensation benefits for at least 5 years?	☐	☐
4. Are you knowledgeable of Oklahoma workers' compensation laws, Commission Rules, the Oklahoma workers' compensation system, the 6th Edition of the AMA Guides to the Evaluation of Permanent Impairment and the Official Disability Guidelines (ODG) published by the Work Loss Data Institute?	☐	☐

5. Describe your training and/or experience as a mediator. *(Attach an extra page if necessary.)*: _____

6. Describe your training and/or experience evidencing knowledge of workers' compensation laws, Commission Rules, the Oklahoma workers' compensation system, the 6th Edition of the AMA Guides to the Evaluation of Permanent Impairment and the Official Disability Guidelines (ODG) published by the Work Loss Data Institute. *(Attach an extra page if necessary.)*:

7. Have you, within the twelve (12) months immediately preceding this application:		
(a) completed six (6) hours of mediation training approved by the Oklahoma Bar Association MCLE Commission or sponsored by the Workers' Compensation Commission, **AND**	☐	☐
(b) observed or mediated at least two (2) workers' compensation mediation sessions?	☐	☐

NOTE: If you answer YES to question(s) 8 and/or 9, please provide an explanation of each on a separate page and attach to this application.

8. Have you been the subject of any disciplinary proceedings in any state for misconduct as a licensed professional that resulted in disbarment, suspension, public censure, private reprimand, or revocation of your professional license?	☐	☐
9. Have you been convicted of a felony or of a crime involving dishonesty or false statement?	☐	☐
10. Will you comply with the Commission's mediation procedures?	☐	☐

I hereby request appointment to the Workers' Compensation Commission's list of certified workers' compensation mediators, and certify that I meet the minimum requirements for certification as a workers' compensation mediator pursuant to 85A O.S. § 110 and the Commission's rules. Upon receipt of a Commission order to serve as a mediator of a claim, I agree to schedule a mediation session within thirty (30) days of the order of appointment, unless otherwise agreed by the parties. I agree to schedule mediations for a minimum two-hour block of time, and to schedule not more than one mediation to take place at a time. I agree to conduct up to two (2) pro bono mediations annually if requested by the Workers' Compensation Commission. I agree to submit biennially to the Commission's Counselor Division written verification of compliance with the continuing education requirements set by 85A O.S. § 110. I agree to accept as payment in full an amount not to exceed the maximum rate or fee set forth in Rule 810:10-3-12 of the Workers' Compensation Commission for services rendered as a certified workers' compensation mediator. I agree to comply with all applicable statutes and the rules of the Workers' Compensation Commission. I agree to comply with all applicable standards of impartiality and confidentiality.

I hereby authorize any and all associations, organizations and State and Federal agencies to release to the Workers' Compensation Commission upon request, any and all documents and information necessary and relevant to the investigation and approval of this application.

I declare under PENALTY OF PERJURY that the statements contained herein are true and correct to the best of my knowledge and belief. I understand that false or misleading information may result in rejection of my application or, if previously appointed, in removal from the list of certified workers' compensation mediators.

Signature _____ Date _____