WORKERS' COMPENSATION COMMISSION
MEDIATION REQUEST FORM

Top portion, including the Responding Party section, to be filled out by party requesting the mediation and returned to the Workers' Compensation Commission Counselor Division, 1915 N. Stiles Avenue Ste 231, Oklahoma City, OK 73105

***REQUESTING PARTY**	**RESPONDING PARTY**
Name ______	Name ______
Address ______	Address ______
City ______	City ______
State ______ Zip ______	State ______ Zip ______
Phone ______	Phone ______
Other Phone ______	Other Phone ______

NATURE OF DISPUTE TO BE MEDIATED: ______________________________

____

____

____
Signature of Requesting Party **Date**

____
Employer (At time of injury, if different from responding party) **Address** **Phone**

Date of Injury ______________

NOTE: If a CC-Form-3 has been filed in this claim, the parties may schedule and proceed with mediation independent of the Commission's Counseling Division or file a CC-Form-13 to request referral by the Administrative Law Judge.

✸ ✸

This portion to be filled out by the Responding Party

RESPONDING PARTY: ☐ Yes, I agree to mediate. ☐ No, I do not agree to mediate.

______________ / ______________ / ______________ / ______________
Signature of Responding Party **Name Printed** **Phone** **Date**

RETURN FORM TO: **Workers' Compensation Commission Counselor Division**
1915 North Stiles Avenue Ste 231
Oklahoma City, OK 73105

Direct Questions to Workers' Compensation Commission Counselor Division
(405) 522-5308 or In-State Toll Free (855) 291-3612
E-Mail: Counselors@wcc.ok.gov

✸ ✸

For Commission Use Only

Date of contact made with responding party: ______________

Agrees to Mediate: ☐ Yes ☐ No

If yes, date consent to mediate was received: ________ If no, date file closed ________

Revised 2-2-16