

OKLAHOMA WORKERS' COMPENSATION COMMISSION MEDIATION SYSTEM

MEDIATION CONFERENCE REPORT

MUST be completed. Please type or print legibly.

Claim for Compensation (i.e. CC-Form-3 or CC-Form-3B) on File With the Workers' Compensation Commission?

Yes (Commission File No. _____)

No

Claimant/Injured Worker (Full Name): _____

Respondent/Employer (Name): _____

Insurer (Name): _____

Check One:

Mediation By Mutual Agreement of the Parties (i.e. No Commission Order of Referral to Mediation)

Commission Ordered Referral to Mediation

1. **Mediation conference date:** _____

2. **Mediation conference location (city and county):** _____

3. **Mediation conference length** _____ **hours** _____ **minutes.**

4. **The case was (circle one letter):**

a. **settled in full;**

b. **not settled;**

c. **settled in part (circle appropriate number):**

(1) **parties reached agreement on one or more issues or claims;**

(2) **case settled as to some parties, but not all parties.**

Mediator

Date

(Send original to Workers' Compensation Commission Counselor Division, 1915 N. Stiles Ave. Oklahoma City, OK 73105)