WORKERS' COMPENSATION COMMISSION
MEDIATION REQUEST FORM

Top portion, <u>including</u> the Responding Party section, to be filled out by <u>party requesting the mediation</u> and returned to the Workers' Compensation Commission Counselor Division, 1915 N. Stiles Avenue, 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: ____

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Signature of Requesting Party **Date**

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

Date of injury: ____________________ Commission File No. (if applicable) ____________________

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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
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

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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 12-18-14