WORKERS' COMPENSATION COMMISSION
MEDIATION REQUEST FORM

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

*REQUESTING PARTY

Name ______________________

Address ______________________

City ______________________

State ______________ Zip ______________

Phone ______________________

Other Phone ______________________

RESPONDING PARTY

Name ______________________

Address ______________________

City ______________________

State ______________ Zip ______________

Phone ______________________

Other Phone ______________________

NATURE OF DISPUTE TO BE MEDIATED: ______________________

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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.

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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 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

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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 2-2-16