

**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, 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: _____

Commission File No. (if applicable) _____



****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



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: _____