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)