

MEDIATION REQUEST

UNDER THE

IRONWORKERS COLLECTIVELY BARGAINED WORKERS' COMPENSATION PROGRAM

Case No. _____

The Employee's Name: _____

Employer's Name: _____

Other Name: _____

("Requesting Party")

hereby requests the ADR Director to schedule a mediation hearing pursuant to the Workers' Compensation Addendum. Requesting Party declares that it made a good faith attempt to resolve the dispute.

The issues are:

Compensation Rate

Rehabilitation

Temporary Disability

Self-procured Treatment

Permanent Disability

Future Medical Treatment

Other: _____

1. If represented by legal counsel, identify: _____
(name, address & telephone number)

2. Has the Employee undergone medical evaluation from a QME or AME: _____. If so, have all
(yes) (no)

adverse parties been served with the medical reports: _____. If not, will a medical evaluation be
necessary: _____.
(yes) (no) (yes) (no)

3. Date Requesting Party will be prepared for Mediation: _____. If longer than 30 days from date
of Request, explain the reasons why: _____

SERVICE

Names and address of parties, including attorneys and representatives, served with a copy of this Mediation Request:

Date: _____

(Signature)

(Address)

(Telephone Number)

Must be timely filed with the ADR Administrator:

Gene Vick

Ironworkers Collectively Bargained Workers' Compensation Program

P.O. Box 542

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