

Union Construction Workers' Compensation Program

Administered by Wilson-McShane Corporation

3001 Metro Drive, Suite 500
Bloomington, MN 55425-1412

Toll Free (800) 535-6373

Phone: (952) 851-3501

Fax: (952) 851-3566

APPLICATION FOR MEDIATION

Employee _____ Date of Injury/Illness _____
Address _____ Social Security No. _____
_____ Employer _____
Telephone _____ Insurer/TPA _____

Date of Facilitator's Determination: _____

Explain the issues/problems presented to the facilitator that remain unresolved:

Intervention Claims: Name, address and telephone number of all parties who have paid benefits related to this claim and health care providers who have not yet been paid for their services:

<u>Name</u>	<u>Address</u>	<u>Telephone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please make certain that the mediator is aware of all intervention claims.

I request mediation due to a dispute regarding a claim filed for Workers' Compensation. I hereby authorize the assigned mediator to be furnished with any information or facts regarding this injury including rehabilitation reports, psychological, aptitude and interest tests, medical records, medical treatment and prognosis, estimates of disability, and recommendation for further treatment. This information is provided for the evaluation and handling of the purported dispute. Further, I understand that if I decide not to attend a scheduled mediation and fail to give the mediator 48 hours notice prior to the scheduled mediation, I will be responsible for the payment of a \$200 cancellation fee.

Filing Party (Employee, Insurer or Employer) Phone Date

Submit copies to all parties, their attorneys, and the Union Construction Workers' Compensation Program.