WORKERS' COMPENSATION COURT
VOLUNTARY 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 Court*

***REQUESTING PARTY**	**RESPONDING PARTY**
______________________________	______________________________
Address ______________________	Address ______________________
City _________________________	City _________________________
State __________ Zip _________	State __________ Zip _________
Phone ________________________	Phone ________________________
Other 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:__________________________ Court Claim # (if applicable)________________

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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**

Please return this form to: Workers' Compensation Court Counselors Program
1915 North Stiles
Oklahoma City, OK 73105
Or fax to: (405) 522-8683
Any Questions call: (405) 522-8600 or 1-800-522-8210

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For Court 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____________
reqfm11-3-97 / **revised 1/03**