

Application for Mediation



UCWCP

Union Construction Workers' Compensation Program
Administered by Wilson-McShane Corporation
www.ucwcp.com

Employee Name _____ Telephone _____

Street Address _____ City _____ State _____ Zip _____

Social Security No. _____ Date of Injury/Illness _____

Employer _____ 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:

Name _____ Address _____ Telephone _____

Name _____ Address _____ Telephone _____

Name _____ Address _____ Telephone _____

Name _____ Address _____ Telephone _____

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) _____ Telephone _____ Date _____

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