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 Determination

Explain the issues/problems presented 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.