# NOTICE OF THE
# REQUEST FOR MEDIATION

**INSTRUCTIONS:**

This form is to be utilized when any party under the Alternate Dispute Resolution Program of the Laborers' Health & Welfare Trust Workers' Compensation Agreement requests **MEDIATION**.

Prior to completion of this form, the parties must have tried to resolve the issue with the **OMBUDSPERSON**.

This form must be filed not more than twenty-five (25) business days after the **OMBUDSPERSON** has responded to the request for assistance.

**EMPLOYEE:**_____ **CONTRACTOR:** _____

**SOCIAL SECURITY #:**_____ **UNION AFFILIATION:**_____

**ADDRESS:** _____ **LOCAL #:** _____

**CITY/ZIP:**_____ **DATE OF INJURY:**_____

**TELEPHONE #:**_____ **CLAIM #:** _____

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The Mediator is requested to resolve the following disputes as the parties disagree on:

_____ Denial, reduction or termination of the employee's benefits.

_____ Employee's disagreement with the findings of the second medical opinion.

_____ Other (Please explain):

**SIGNATURE:** _____ **DATE:** _____

Return completed form to: Barbara Shogren Lies, OMBUDSPERSON @ 7177 Brockton Ave., Suite 101, Riverside, CA 92506. Phone: 800-905-7595 FAX: 951/788-0320

Copies Served On:

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Date received by Ombudsperson:

Date received by Mediator: