

**Virginia Workers' Compensation Commission
Request for Mediation**

VWC File No: _____

Date of Injury: _____

Claimant's Social Security No: _____

Party Requesting Mediation:

Name _____

Home Phone: (____) _____

Work Phone: (____) _____

Address (Number, Street, Apt., City, State and Zip):

You are (circle one): (Claimant) (Employer) (Insurer) (Health Care Provider)

Describe the issue that you believe should be the subject of the mediation:

I consent to mediation of this matter by an employee of the Virginia Workers' Compensation Commission. I understand if one of the other parties objects to this request the matter will not be referred for mediation.

Your Signature: _____ **Date:** _____

Print Your Name Here: _____

Mail this form to: _____, Ombudsman
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220
FAX: (804) 367-9740