

Virginia Workers' Compensation Commission
Request for Mediation

VWC/JCN File Number: _____

Date of Injury: _____

Person Requesting Mediation:

- Claimant Claimant Attorney
 Claims Administrator Claims Administrator Attorney
 Other: _____

Name: _____

Phone #: (____) _____

Fax #: (____) _____

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

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.

Signature: _____ **Date:** _____

Mail or Fax this form to:
Mediation Scheduler
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220
FAX: 804-823-6904