



Jurisdiction Claim Number (JCN)

Date of Mediation

The parties and their counsel are requested to complete this Pre-Mediation Statement and file the same with the Commission no later than SEVEN (7) days prior to the mediation scheduled in this matter. The purpose of this document is to assist the mediator in preparing for the scheduled mediation.

THE PARTIES MAY COMPLETE THIS FORM JOINTLY OR SEPARATELY. ONCE COMPLETED, IT MAY BE FAXED TO THE ADR DEPARTMENT (804-823-6904) OR UPLOADED INTO WEBFILE AS A CONFIDENTIAL ADR DOCUMENT. As a Confidential ADR Document, only the mediator and party submitting this document will be able to view it in WebFile. Additionally, any party may submit a letter or other documentation as a Confidential ADR Document to provide additional information or insight that might be helpful to the mediator.

IF FILED BY ONE PARTY, I AGREE THE MEDIATOR MAY SHARE THE INFORMATION IN THE PRE-MEDIATION STATEMENT WITH THE OPPOSING PARTY/IES. Yes No

PLEASE INITIAL _____

This form is being completed by: (Select all that apply)

Claimant's Counsel

Other

Employer's Counsel

Please Specify: _____

Do the parties have authority to resolve this claim? Yes No

General Background

Is this an accepted claim? Yes No

If not accepted, are there any accepted issues? If so, please list the issues upon which the parties agree:

Is there an agreed average weekly wage? Yes No If so, \$_____

If not, please provide:

The claimant's calculation: \$_____ The employer's calculation: \$_____

Is there an agreement on all or some of the injuries? Yes No

If yes, please identify: _____

If benefits have been paid voluntarily, how many weeks have been paid through the mediation date? _____

Prior Settlement Discussions

Has there been a demand? If so, please state the last demand: \$_____

Is the demand still current/valid: Yes No

Has there been a response to the demand? If so, please state the last response: \$_____

Is the last response to the demand still current/valid: Yes No

Ancillary Issues/Terms

Is there a third-party claim? If so, have the parties discussed any waiver of the employer/insurer's subrogation rights? Yes No N/A

Have the parties discussed whether the employer expects a resignation/release of claims? Yes No

If so, has a copy of the resignation/release of claims been shared with claimant's counsel? Yes No



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Medicare Set-Aside

If an MSA is required, has the MSA evaluation been received? Yes No N/A
Has it been approved? Yes No
Has it been provided to the opposing party? Yes No
Do the parties agree that the MSA adequately provides for all of the claimant's compensable injuries or potential injuries? Yes No
Are the parties aware of any conditional payments made by Medicare? Yes No

Miscellaneous

Are any additional medical reports needed and/or anticipated? Yes No If yes, please explain/describe:
Are there any other issues about which the mediator should be aware? (i.e., medical status, pending disputes, etc.) If so, please explain briefly.
Who will be attending the mediation and how will they attend (in person or via telephone)? (in addition to the parties, please identify employer representatives, family members, interpreters and any other third parties)
Is there any other information you believe will be helpful to the mediator that is not readily available from a review of the Commission's file?

By signing below, I represent that my client agrees to participate in this mediation in good faith and is prepared to proceed with the mediation as scheduled. I also represent that I have, or anticipate that I will have, sufficient authority by the date of the scheduled mediation.

Counsel for the Claimant DATE

Counsel for the Employer DATE

Counsel for Additional Party (Please Specify) DATE