TENNESSEE BUREAU OF WORKERS' COMPENSATION
IN THE COURT OF WORKERS' COMPENSATION CLAIMS
AT _____

Employee Name Here, **Employee,**	)	**Docket Number:**
v.	)	**State File Number:**
Employer Name Here, **Employer,**	)	**Date of Injury:**
Insurance Carrier Name Here, **Carrier,**	)	**Judge:** (To be assigned)
and (if applicable) Abbie Hudgens, Administrator of the Bureau of Workers' Compensation and Subsequent Injury Fund and Vocational Recovery Fund.	)	

REQUEST TO RESUME MEDIATION

Requesting party name requests that the parties resume mediation with a Tennessee Bureau of Workers' Compensation mediator under Tennessee Code Annotated section 50-6-236. Requesting party name states the following:

1. A Petition for Benefit Determination was previously filed and is pending before the Court of Workers' Compensation Claims. (If a party's contact information has changed, please update it below. Attach a separate document if more space is needed.)

   _____

   _____

2. The previous mediation concluded with the issuance of a Dispute Resolution Statement by _____, the assigned mediator, a copy of which is attached.

3. A Dispute Certification Notice has not been issued. (If a Dispute Certification Notice has been issued, file a motion with the Court Clerk.)

4. Additional disputes for the following benefits have arisen for mediation:

   ☐ Medical Benefits, ☐ Temporary Disability Benefits,

   ☐ Permanent Disability Benefits, MMI Date _____ Impairment Rating _____

   or ☐ Other _____

5. A brief explanation of the current issue is: _____
_____
_____

6. All parties have been contacted and agreed upon the three dates and times below for mediation:

_____	_____	_____
9:00 a.m. or 1:00 p.m.	9:00 a.m. or 1:00 p.m.	9:00 a.m. or 1:00 p.m.

Or: ☐ I am unable to coordinate dates with the other party; the dates above only show my availability.

Respectfully Submitted,

_____
Signature/Date

CERTIFICATE OF SERVICE

The requesting party must serve a copy of this document on all parties and counsel of record. The undersigned certifies on this ___day of _____,20___ that he/she served a true and correct copy of the document and its attachments by facsimile, email and/or U.S. Mail, first class postage prepaid, to the following:

☐**Employee**_____
Service by: ☐Hand-Delivery ☐Mail ☐ Facsimile ☐Email
Service Sent to: _____

☐**Employer(s)**_____
Service by: ☐Hand-Delivery ☐Mail ☐ Facsimile ☐Email
Address: _____

☐**Employee's Attorney**_____
Service by: ☐Hand-Delivery ☐Mail ☐ Facsimile ☐Email
Address: _____

☐**Employer(s)' Attorney(s)**_____
Service by: ☐Hand-Delivery ☐Mail ☐ Facsimile ☐Email
Address: _____

☐**Carrier(s)**_____
Service by: ☐Hand-Delivery ☐Mail ☐ Facsimile ☐Email
Address: _____

☐**Subsequent Injury Fund's Attorney**_____
Service by: ☐Hand-Delivery ☐Mail ☐ Facsimile ☐Email
Address: _____

_____
Signature

_____
Printed Name

Upon receipt of this form, a Bureau of Workers' Compensation mediator will be assigned to help resolve the dispute. Please file this form with the Court of Workers' Compensation Claims via mail at 220 French Landing Drive, 1B, Nashville, TN 37243-1002; email PBD.courtclerk@tn.gov; or Fax: 615-253-2480.