

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

	<u>,</u>) Docket Number:				
	Employee,) State File Number				
v.	,) State File Number:				
	Employer,) Date of Injury:				
	Carrier, nd f applicable) roy Haley, Administrator of the) Judge:))				
Bı Su	ureau of Workers' Compensation and absequent Injury Fund and ocational Recovery Fund.))				
	REQUEST TO	RESUME MEDIATION				
Bure	requests that the parties resume mediation with a Tennessee Bureau of Workers' Compensation mediator under Tennessee Code Annotated section 50-6-236. states the following: 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 I	Disability Benefits,				
	☐ Permanent Disability Benefits, MM or ☐ Other	II Date Impairment Rating				

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5.	A brief explanation of the current 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: \[\square I am unable to coordinate dates with the other party; the dates above only show my availability. \]							
	Respectfully Submitted,							
	Signature/Date							
	CERTIFI	CATE OF SERV	VICE					
on this	questing party must serve a copy of this docum sday of,20 that he/she served nile, email and/or U.S. Mail, first class postage	a true and correc	t copy of the document ar					
□Em	ployee		Employer(s)					
	ce by: Hand-Delivery Mail Facsimile ce Sent to:		Service by: Hand-Delivery					
□Em	ployee's Attorney	[□Employer(s)' Attorney(s)					
	ce by: Hand-Delivery Mail Facsimile ess:		Service by: Hand-Delivery					
□Car	rrier(s)	[□Subsequent Injury Fund's A	Attorney				
Servic	ce by: \square Hand-Delivery \square Mail \square Facsimile \square	Email S	Service by: □Hand-Delivery	\square Mail	$\ \square \ {\it Facsimile}$	□Email		
Addre	ess:		Address:					
		Signature						
		Printed Name	e					

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.

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