Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
http://www.tn.gov/workforce/section/injuries-at-work

REQUEST FOR MEDIATION

(For injuries prior to 7/1/2014 only)
This form replaces the Request for Assistance (C40A), the Request for Benefit Review Conference (C40B) and the Certificate of Readiness (C40R).

This request is for:

☐ Lost Wage Benefits ☐ Medical Benefits ☐ Discovery
☐ Penalty (For Late or Non-Payment of wages) ☐ Lifetime Medical Coverage

OR

☐ A Benefit Review Conference:

☐To keep the statute of limitations from running or,

☐For mediation--I am ready to proceed to mediation in a Benefit Review Conference.

Date of MMI _____ Impairment Rating Assigned _____

If applicable, the Subsequent Injury Fund Attorney is _____ & he/she has been notified.

The parties have discussed possible dates for conducting the mediation and <u>all parties or their representatives have agreed upon the three dates and times listed below.</u> Please provide dates and circle the desired time slots.

_____	_____	_____	_____	_____
9:00am or 1:00 pm	9:00am or 1:00 pm	9:00am or 1:00 pm	Signature of Requesting Party	Signature of Opposing Party

Please give a brief description of the disputed issues: _____

_____

Date of Injury _____ TN County of Injury (Name state if injury not in TN)_____

Employee Name _____ SSN _____ Date of Birth _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Phone _____ Email _____

Employee Attorney _____BPR # _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Employer _____ Phone _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Employer Contact Person_____ Email _____

Employer Attorney _____ BPR # _____

Phone _____ Fax _____ Email _____

Office Contact Person_____ Email _____

Insurance Company or TPA: _____

Ins. Adjuster Name _____Email _____

Mailing Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

REQUESTING PARTY

I hereby request the Tennessee Bureau of Workers' Compensation to assist in any disputed workers' compensation issues related to the above-detailed injury. I also authorize the Bureau to contact any person who has information regarding that injury.

_____	_____	_____
Printed name	**Signature**	**Date**

Please return the completed form to the office below that is closest to the Employee's home address.

Chattanooga
Tennessee Bureau of Workers' Compensation
1301 Riverfront Pkwy., Ste. 202
Chattanooga, Tennessee 37402
Fax: 423-634-3115

Cookeville
Tennessee Bureau of Workers' Compensation
444 – A Neal Street
Cookeville, Tennessee 38501-027
Fax: 931-520-4316

Gray
Tennessee Bureau of Workers' Compensation
5788 Bobby Hicks Hwy.
Gray, TN 37615
Fax: 423-239-7844

Jackson
Tennessee Bureau of Workers' Compensation
225 Dr. Martin L. King Jr. Dr.
1st Floor, Suite 120, Box 16
Jackson, TN 38301-6920
Fax: 731-265-7022

Knoxville
Tennessee Bureau of Workers' Compensation
520 Summit Hill, Ste. 103
Knoxville, TN 37902
Fax: 865-594-5172

Memphis
Tennessee Bureau of Workers' Compensation
One Commerce Square
40 South Main St., Ste. 500
Memphis, TN 38103-1820
Fax: 901-543-6039

Murfreesboro
Tennessee Bureau of Workers' Compensation
845 Esther Lane
Murfreesboro, TN 37129-5537
Fax: 615-217-9378

Nashville
Tennessee Bureau of Workers' Compensation
220 French Landing Drive, 1-B
Nashville, Tennessee 37243-1002
Fax: 615-253-1223