**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 Second 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

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

**Kingsport**
Tennessee Bureau of Workers' Compensation
1908 Bowater Drive
Kingsport, TN 37660-4136
Fax: 423-224-2056

**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

**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