



STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
WORKERS' COMPENSATION DIVISION  
(651) 361-7900

**Mailing Address:**

P.O. Box 64620  
St. Paul, MN 55164-0620

**Office Address:**

600 North Robert Street  
St. Paul, Minnesota 55101

WID: \_\_\_\_\_

DOI: \_\_\_\_\_

, Employee,

Attorney,

v.

**OAH MEDIATION REQUEST**

, Employer,

Attorney

and

, Insurer

Attorney,

Intervenor/Representative.

**DO NOT ATTACH ANY CONFIDENTIAL INFORMATION TO THIS REQUEST.**  
**REQUEST MAY BE FILED BY E-MAIL, FACSIMILE OR MAIL TO ABOVE ADDRESS.**

**DO NOT SEND TO DEPT. OF LABOR AND INDUSTRY**

**Party requesting Mediation:** name, address, telephone number, e-mail address

**All parties agree to participate in mediation:** Yes \*No \*Do not know

\*Explain

1. I have received and read the information on OAH Mediation and agree to the terms. Yes No

2. The Compensation Judge is granted permission to review the entire OAH file for any pending pleadings. Yes No

**3. Please state issues and disputes:**

**4. Please provide a brief statement of the case:**

**5. Scheduling**

Amount of time you request      ½ day      full day      other

Available dates: attach calendar, if convenient

**6. Is an interpreter necessary for the Mediation?**

Yes:                      No.

Language requested:

\_\_\_\_\_  
Attorney Representing Employee/      Date  
Employer/Insurer Signature/Pro Se

\_\_\_\_\_  
Print Name

Revised 10/27/2010 cls