

Filed Date Stamp Here

DISPUTE CERTIFICATION NOTICE

Bureau of Workers' Compensation Court of Workers' Compensation Claims

Docket No	
State File No./YR	/
RFA No	
Date of Injury:	

			rkforce/section/injuries-at-work rc.courtclerk@tn.gov	RFA No				
			800-332-2667		Date of Injury:			
This [DISPUTE (CERTIF	ICATION NOTICE is be	ing issued due to an unresolve	ed:			
	Mediation regarding temporary disability and/or medical benefits							
Emplo	oyee Nan	ne:						
Emplo	oyer(s) N	ame(s)	:					
Carrie	er(s) Nam	ne(s):						
Secor	nd Injury	Fund A	ttorney:					
Body	Part(s) In	njured:						
			<u>w</u>	AGE INFORMATION				
	•		- , ,	vee's average weekly wage is \$	and the compensation rate is			
			er week. o not agree as to the E	Employee's average weekly wa	age or worker's compensation rate per			
			<u>!</u>	MEDICAL RECORDS				
The p	arties:	□н	ave exchanged medica	al records	hanged medical records			
		□н	ave exchanged medica	al records and agreed to their	admissibility in future hearings			
		□ TI	here are no medical re	ecords to exchange				
				DISPUTED ISSUES				
Issues	s in dispu	te (che	eck all that apply):					
	·		Jurisdiction		Temporary Disability Benefits			
			Compensability		Permanent Disability Benefits			
			Medical Benefits		Other (please use additional sheets)			
	Number of sheets?							
				DEFENSES				
List al	ll defense	es assei	rted by Employer (plea	ase specify and use additional	sheets if necessary)			
				· · ·				
	Additi	onal sh	eets detailing defense	s are attached. Number	of sheets?			
				Mediator's Signature	Date			

Print Mediator's Name

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	INCLUSION OF ADDITIONAL ISSUES None of the parties submitted a list of additional issues for inclusion in this dispute certification notice after a copy of the notice was provided to the parties.							
	A party submitted a list of additional issues for inclusion in this dispute certification notice after a copy of the notice was provided to the parties (if this box is checked a copy of the list(s) must be attached to this document. Also, the following information must be provided for each party that submitted a list of additional issues).							
	Name of Party:		Name of Party:_					
	Date List Received by Mediator:	Date List Received by Mediator:						
Number of Pages Submitted:			Number of Pages Submitted:					
	Name of Party:	Name of Party: Date List Received by Mediator:						
	Date List Received by Mediator:							
	Number of Pages Submitted:		Number of Pages	s Submitted:				
	CERTIFICATION BY By the inclusion of my signature below, I, the mediate tion notice are complete and accurate, that the parties at the parties and that this dispute certification.	or in this	matter, hereby a ne inclusion of the	foregoing docum	ents, to the best of my			
	Petition for Benefit Determination Position Statements Wage Statement Medical Records List(s) of Additional Issues List(s) of Defenses Raised Affidavits							
with the	ther certify that a true and correct copy of this dispute clerk and a true and correct copy was forwarded to the uments listed above and attached to the Dispute Certificed into evidence during a hearing before the Court. It is apply to all hearings before the Court.	parties on fication N The Ten	this theday otice will not be conessee Rules of Conessee	ofonsidered by the	Court unless properly			
	oyee							
	y: □Hand-Delivery □Mail □ Facsimile □Email		y: \square Hand-Delivery					
Service	Sent to:	Service	Sent to:					
□Empl	oyee's Attorney	□Empl	over(s) Attornev(s)				
	y: □Hand-Delivery □Mail □ Facsimile □Email		y: □Hand-Delivery					
Service	Sent to:	Service	Sent to:					
□Carri	er(s)	□Seco	nd Iniury Fund's At	tornev				
	ıy: □Hand-Delivery □Mail □ Facsimile □Email		y: □Hand-Delivery	-				
Service	Sent to:							
	Me	ediator's S	ignature	Dat	 e			

Print Mediator's Name