MEDIATION REQUEST FORM

Date: _____

By completing this form and sending it to the Department, you are requesting a mediation. You will be contacted by phone to schedule the mediation within two to three weeks.

Name: _____

Address: _____

_____

Social Security No: _____

Date of Injury: _____

Daytime Phone No: _____

(where you can be reached to schedule the mediation)

Please list all of the issues you would like to discuss during the mediation. In addition, attach any documents you have to support your position, including any medical records.

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Please send this form to: ‘

South Dakota Department of Labor
Division of Labor and Management
700 Governors Dr.
Pierre, SD 57501

Phone: (605) 773-3681
Fax: (605) 773-4211