ARBITRATION REQUEST

UNDER THE

BASIC CRAFTS WORKERS' COMPENSATION BENEFITS TRUST FUND ADDENDUM

Case No. _____

The [ ] Employee's Name: _____
[ ] Employer's Name: _____
[ ] Other Name: _____
("Requesting Party")
hereby requests the ADR Director to schedule an arbitration hearing pursuant to the Workers' Compensation Addendum. Requesting Party declares that it made a good faith attempt to resolve the dispute at Informal Conciliation.

The issues are:

[ ] Compensation Rate
[ ] Temporary Disability
[ ] Permanent Disability
[ ] Other: _____

[ ] Rehabilitation
[ ] Self-procured Treatment
[ ] Future Medical Treatment

1. If represented by legal counsel, identify: _____
(name, address & telephone number)

2. Has the Employee undergone medical evaluation from a QME or AME: ____ (yes) ____ (no). If so, have all adverse parties been served with the medical reports: _____ (yes) _____ (no). If not, will a medical evaluation be necessary: _____ (yes) _____ (no).

3. Date Requesting Party will be prepared to present evidence at an arbitration hearing: _____. If longer than 30 days from date of Request, explain the reasons why: _____

4. If Requesting Party is an Employee, the Employee hereby declares that he or she understands that, upon the filing of this Arbitration Request, the Ombudsman will no longer aid or counsel him or her regarding issues covered by this Request, in accordance with the Workers' Compensation Addendum.

SERVICE

Names and address of parties, including attorneys and representatives, served with a copy of this Arbitration Request:

_____ _____
_____ _____
_____ _____

Date: _____

_____
(Signature)

_____
(Address)

_____
(Telephone Number)

Must be timely filed with the ADR Director:
Arthur Scears
Basic Crafts Workers' Compensation Benefits Trust Fund
822 C Street, #150
Hayward, CA 94543
Telephone: (510) 568-5920; Fax: (510) 568-5279