STATE OF VERMONT – Department of Labor
Workers' Compensation Alternative Dispute Resolution Report
Report due from mediator within 15 days of completion of mediation

Claimant name		State File No.:	
Defendant name			

Date of ADR Session		Starting Time		Finishing Time	

1. Please indicate the names and addresses of all persons participating in the ADR Session. (If additional space is needed, please attach an additional sheet.) If any party is a corporation or other entity, please indicate the name and title of the representative. Identify with an asterisk the representative of each party who had decision-making authority.

Participants	Name	Mailing Address	City, State & Zip Code
Claimant			
Claimant's Counsel			
Defendant/Insurer			
Defendant/Insurer Counsel			
Employer representative			
Interested party			
Interested party			

2. Were all appropriate parties in attendance? Yes ☐ No ☐
If not, who failed to appear?
List and summarize any substitute arrangement made regarding attendance at the ADR Session.

3. Was full or partial settlement reached at the session? Full ☐ Partial ☐
If so, please summarize and append any agreement of the parties.

_____ _____
Mediator Date