FORM 19A

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 19
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 7470 in Mass. Outside Mass. 617-727-4900 ext. 7470
http://www.mass.gov/dia

DIA Board #
(if known)

SECTION 19A MEDICAL MEDIATION AGREEMENT

1. Employee's Name (Last, First, MI) and Address (No., Street, City, State, Zip):	2. Social Security Number*:
3 Employer Name and Address (No., Street, City, State, Zip):	
4. Insurer/Address (No., Street, City, State, Zip):	5. Date of Injury (mm/dd/yyyy):

THE PARTIES AGREE AS FOLLOWS:

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ATTORNEY FEE: $ _____

This agreement does not forfeit the parties' rights to raise any other claims or defenses.

6. Employee/Claimant Signature: (*REQUIRED*)	**7. Date (mm/dd/yyyy):**
8. Employee Counsel Signature:	**9. Date (mm/dd/yyyy):**
10. Insurer Counsel/Claims Rep. Signature:	**11. Date (mm/dd/yyyy):**

APPROVAL FOR THE DEPARTMENT BY:

NAME: _____ TITLE: _____ DATE:_____

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of your claim.**