Community Action Partnership
Riverside County
Dispute Resolution Center
Mediation Referral

DATE: _____ / _____ / _____

MONTH DAY YEAR

PLEASE PRINT ALL INFORMATION

AGENCY USE ONLY:

AGENCY MAKING REFERRAL

PERSON MAKING REFERRAL – TITLE

( ) ( )

AGENCY TELEPHONE # AGENCY FAX #

PARTIES IN DISPUTE

1. _____

LAST NAME FIRST NAME MIDDLE INITIAL

_____

ADDRESS APT #

_____ / _____ / _____

CITY STATE ZIP CODE

(_____) _____ / _____ _____

TELEPHONE # BEST TIME TO CALL

2. _____

LAST NAME FIRST NAME MIDDLE INITIAL

_____

ADDRESS APT #

_____ / _____ / _____

CITY STATE ZIP CODE

(_____) _____ / _____ _____

TELEPHONE # BEST TIME TO CALL

REASON FOR REFERRAL_____

_____

_____

_____

REFERRAL OUTCOME: _____

_____

_____

_____

_____

MEDIATION SERVICES ARE PROVIDED FOR A MINIMAL FEE. YOU WILL BE CONTACTED WITHIN 48 HOURS (EXCLUDING WEEKENDS AND HOLIDAYS) TO SCHEDULE AN APPOINTMENT FOR MEDIATION.

FAX A COPY TO: 951.955.6506

2038 IOWA AVE. SUITE B102

RIVERSIDE CA. 92507