

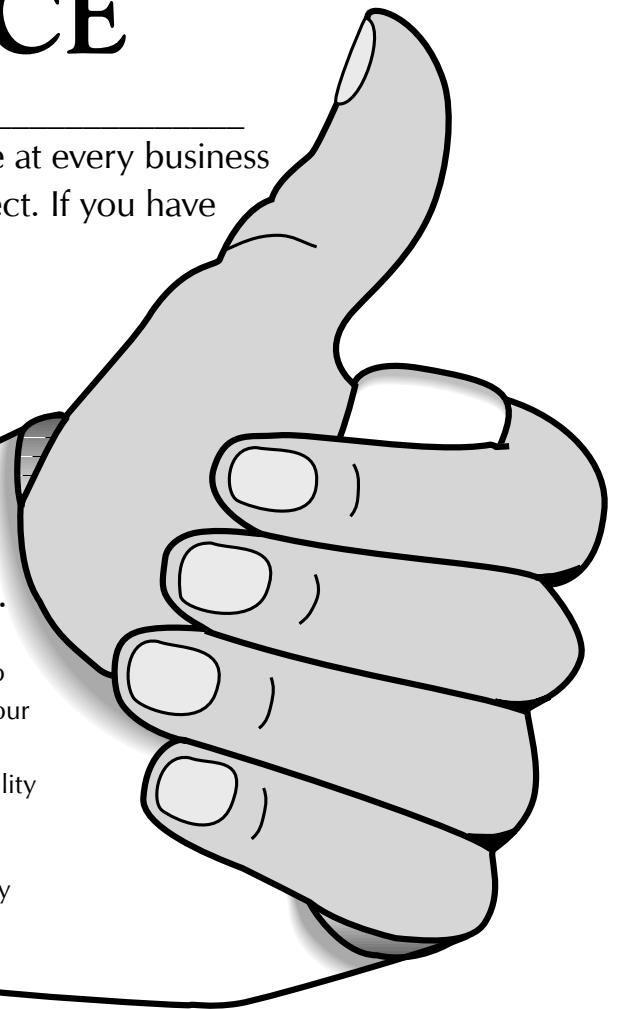
# NOTICE OF COMPLIANCE

This employer complies with the Oregon Workers' Compensation Law. Coverage started \_\_\_\_\_ and remains in effect until terminated. Employers must post this notice in a conspicuous place at every business location. It is illegal to permit this notice to remain posted when insurance is no longer in effect. If you have questions or need additional notices: Call (503) 947-7814 or (503) 947-7993/TTY.

## Notice to worker:

If you are injured on the job, you should —

- 1** **Notify your employer right away.** If you seek medical treatment, tell the doctor that you were hurt on the job. Give your doctor the insurer and policy information shown below. A workers' compensation claim can be filed by completing Form 801, available from your employer.
- 2** **Stay in touch with your employer and your doctor.** Your employer may have light-duty work you can do while you recover. Only your attending physician may authorize temporary disability payments.
- 3** **If you have questions, contact your employer or the insurer.** You also may contact the Workers' Compensation Division (benefit consultants) at (800) 452-0288 or (503) 947-7993/TTY or the Ombudsman for Injured Workers (advocate) at (800) 927-1271.



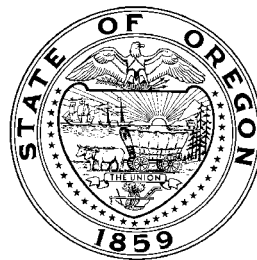
Insurer:

Policy no.:

Employer:

BIN:

WCD no.:



Cory Streisinger, Director  
Department of Consumer & Business Services

440-1188 (2/06/COM)

**Employer: Use the postcard below to make comments or recommendations, to order additional posters, or to order Spanish-language supplements.**

You can order online at: [www.wcd.oregon.gov](http://www.wcd.oregon.gov)

**Worker:** Give this card to the doctor who treats your job injury.  
**Trabajador:** Entregue esta carta al doctor que trata su lesión de trabajo.  
**Employer:**

BIN: \_\_\_\_\_  
WCD no.: \_\_\_\_\_ (over)

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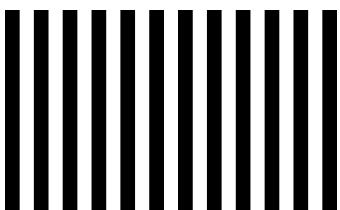
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Return name & address

**BUSINESS REPLY MAIL**  
FIRST-CLASS MAIL PERMIT NO. 1266 SALEM OR  
POSTAGE WILL BE PAID BY ADDRESSEE  
WORKERS' COMPENSATION DIVISION - EMPLOYER COVERAGE  
DEPT OF CONSUMER & BUSINESS SERVICES  
350 WINTER ST NE RM 21  
SALEM OR 97301-9920

NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES



**BIN:**

**WCD no.:**

Comments or recommendations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Send \_\_\_\_\_ additional copies of the English-language Notice of Compliance poster.

Send \_\_\_\_\_ copies of the Spanish-language supplement (to be posted beside the English-language poster).

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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**Physician:** If you have provided treatment for an on-the-job injury or illness, send Form 827 to:

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