

INJURED ON THE JOB?

What should I do?

Notify your employer right away and ask for a Form 801 "Report of Job Injury or Illness." You have the right to file a claim if you are injured on the job.

What does my employer have to do?

Your employer must give you the Form 801 "Report of Job Injury or Illness." Then, your employer must give notice of your claim to the insurer.

How do I get medical treatment?

Get medical treatment from a doctor or other health care professional of your choice. Your employer cannot choose your health care provider. Some providers have limits on the services they offer, so ask your provider about these limits. Give your employer's name and insurance information listed below to your health care provider.

What if I can't do my job?

Your health care provider may approve time off work. The insurer will tell you if you are eligible for benefits. Your employer may have light-duty work you can do while you recover.

It is important to stay in contact with your employer and your insurer.

If you have questions, you may contact the Ombudsman for Injured Workers at 800-927-1271 or the Workers' Compensation Division at 800-452-0288. You can find the most current information about your employer's workers' compensation insurance at WorkCompCoverage.wcd.oregon.gov.

NOTICE OF COMPLIANCE

This employer provides workers' compensation insurance for on-the-job injuries.

Insured policy holder:

Employer:

Insurer:

Policy no.:

Printed:





DEPARTMENT OF
CONSUMER
& BUSINESS
SERVICES
Workers' Compensation Division
P.O. Box 14480
Salem, OR 97309-0405

Address Service Requested



Oregon Workers' Compensation *REQUIRED POSTING* notice

NOTICE OF COMPLIANCE

Employer:

- Post this notice in each business location in a place where your employees can see it. It is illegal to post this notice when workers' compensation insurance is not in effect.
- Give the insurance and employer information listed at the bottom of the notice to injured workers for their health care provider's billing needs.
- Notify your insurer of a worker's injury within five (5) days of your knowledge of a claim or accident that may result in a compensable injury.
- If you have questions about workers' compensation insurance, call the Workers' Compensation Division at 800-452-0288.
- To order additional posters, Spanish language posters, or to get **Notice of Compliance** information in other languages, call 503-947-7814 or go online to WorkCompPoster.wcd.oregon.gov.
- To look up employer coverage information, go online to WorkCompCoverage.wcd.oregon.gov.

Provider instructions

The worker completes
the worker section of this form for the following:

- First report of injury or disease
- Request for acceptance of a new or omitted medical condition
(“Omitted” refers to a condition the worker thinks should have been included among the conditions accepted by the insurer.)
If the worker checks this box, it initiates a claim processing decision by the insurer that may negatively affect the worker’s benefits. If the worker has questions, he or she may consult an attorney or the Ombudsman for Injured Workers at 1-800-927-1271 (toll-free).
- Report of aggravation of original injury
(“Aggravation” means the actual worsening of a compensable condition resulting from the original injury.)
- Notice of change of attending physician or nurse practitioner.* This means the new provider will be primarily responsible for treatment.
Being primarily responsible does NOT include:
 - *Treatment on an emergency basis*
 - *Treatment on an “on-call” basis*
 - *Consulting*
 - *Specialist care (unless the specialist assumes complete control of care)*
 - *Exams done at the request of the insurer or the Workers’ Compensation Division*

*Oregon nurse practitioners, chiropractic physicians, naturopathic physicians, and physician assistants must certify with the Workers’ Compensation Division to treat workers’ compensation patients and get paid.

After the worker has completed and signed Form 827, give the worker copies of Form 827 and Form 3283 (included with this packet) immediately.

The worker does NOT complete
the worker section of this form if the provider chooses to use it for the following:

- Progress report
 - Closing report
 - Palliative care request
(Palliative care makes the worker feel better but does not cure a condition. The worker must be in the workforce or in a vocational program to be eligible for palliative care.)
The following are not palliative care:
 - *Prescriptions, prosthetics, braces, and doctors’ appointments to monitor them*
 - *Diagnostic services*
 - *Life-preserving treatments*
 - *Curative care to stabilize an acute waxing and waning of symptoms*
 - *Services to a permanently and totally disabled worker*
- When requesting palliative care approval from the insurer, include the following in your request:
- *Who will provide the care*
 - *Modalities ordered, including frequency and duration*
 - *How the need for care is related to the accepted conditions*
 - *How the care will enable the worker to continue current work or vocational training.*

For these reports, you have the option of filing Form 827, submitting chart notes, or submitting a report that includes data gathered on Form 827.

Questions about name/address of insurer: 503-947-7814 or WorkCompCoverage.wcd.oregon.gov

Questions about medical issues: Contact the medical resolution team at 503-947-7606.

For health care providers: www.OregonWCdoc.info

Worker's and Health Care Provider's Report for Workers' Compensation Claims

OPTIONAL	WCD employer no.:
	Policy no.:

Worker or provider	Note to Provider: Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.			Dept. Use	
	Worker's legal name, street address, and mailing address:			Ins. no.	
	Language preference:		Male/female <input type="checkbox"/> <input type="checkbox"/>	Occ.	
	Claim no. (if known):		Date/time of original injury:	Nature	
	Phone:	Date of birth:	Occupation:	Last date worked:	Part
	Employer at time of original injury — name and street address:			Event	
Health insurance company name and phone:			Source		
Workers' compensation insurer's name, address:			Assoc. object		
Phone:					

Worker	Worker: Check reason for filing this form, answer questions (if any), and sign below.		
	<input type="checkbox"/> First report of injury or disease (Do not complete or sign if you do not intend to make a claim.) Have you injured the same body part before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: _____	Check here if you have more than one job. <input type="checkbox"/>	
	<input type="checkbox"/> Request for acceptance of a new or omitted medical condition on an existing claim Checking this box initiates claim processing decisions that may affect your benefits. If you have questions, consult with your attorney or the Ombudsman for Injured Workers at 1-800-927-1271 (toll-free). Condition: _____	Describe accident:	
	<input type="checkbox"/> Notice of change of attending physician or nurse practitioner Reason for change: _____		
	<input type="checkbox"/> Report of aggravation of original injury (actual worsening of a compensable condition)		
	By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)		
<input checked="" type="checkbox"/> _____ <i>Worker's signature</i>		_____ <i>Date</i>	

Provider	Provider: If worker initiated this report, give worker a copy immediately.		
	If the worker filed this report for:		
	<ul style="list-style-type: none"> • First report of injury or illness – Send this form to the workers' compensation insurer within 72 hours of visit. • New or omitted medical condition – Attach chart notes that explain how this condition is causally related to the compensable injury. Send this form to the insurer within five days of visit. • Change of attending physician or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. Send this form to the insurer within five days after the change or the date of first treatment. Check the following, if applicable: <input type="checkbox"/> I request insurer to send its records. • Aggravation of original injury – Sign this form and send it to insurer within five days of visit. 		
	If filing for progress report, closing report, or palliative care request, check the appropriate box below.		
	<input type="checkbox"/> Progress report OR <input type="checkbox"/> Closing report (See instructions in Bulletin 239.) <input type="checkbox"/> Palliative care request – Complete remainder of form, except Section b. Attach a palliative care plan; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.		
	a	Date/time of first treatment:	Last date treated:
	Next appointment date:	Est. length of further treatment:	If yes, name hospital: Current diagnosis per ICD-10-CM codes:
b	Has the injury or illness caused permanent impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Impairment expected <input type="checkbox"/> Unknown		Medically stationary? <input type="checkbox"/> Yes (date): _____ (Attach findings of impairment, if any.) <input type="checkbox"/> No (anticipated date): _____
	Work ability status:		
	<input type="checkbox"/> Regular work (job at injury) authorized start (date): _____		through (date, if known): _____
	<input type="checkbox"/> Modified work authorized from (date): _____		through (date, if known): _____
	<input type="checkbox"/> No work authorized from (date): _____		
c	Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).		

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online: WorkCompCoverage.wcd.oregon.gov
To order supplies of this form, call 503-947-7627.

Provider's name, degree, address, and phone: (<i>print, type, or use stamp</i>)		—Original and one copy to insurer —Retain copy for your records —Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner
X	_____	
<i>Provider's signature</i>	<i>Date</i>	

Notice to worker

Claim acceptance or denial

In most instances, you will receive written notice from your employer's insurer of the acceptance or denial of your claim within 60 days. If your employer is self-insured, your employer or the company your employer has hired to process its workers' compensation claims will send the notice to you. If the insurer or self-insured employer denies your claim, it will explain the reason for the denial and your rights.

Medical care

The health care provider must tell you if there are any limits to the medical services he or she may provide to you under the Oregon workers' compensation system.

If your claim is accepted, the insurer or self-insured employer will pay medical bills due to medical conditions the insurer accepts in writing, including reimbursement for prescription medications, transportation, meals, lodging, and other expenses up to a maximum established rate. You must make a written request for reimbursement and attach copies of receipts. Medical bills are not paid before claim acceptance. Bills are not paid if your claim is denied, with some exceptions. Contact the insurer if you have questions about who will pay your medical bills.

Payments for time lost from work

In order for you to receive payments for time lost from work, your health care provider must notify the insurer or self-insured employer of your inability to work. After the original injury, you will not be paid for the first three calendar days you are unable to work unless you are totally disabled for at least 14 consecutive calendar days or you are admitted to a hospital as an inpatient within 14 days of the first onset of total disability.

You will receive a compensation check every two weeks during your recovery period as long as your health care provider verifies your inability to work. These checks will continue until you return to work or it is determined further treatment is not expected to improve your condition. Your time-loss benefits will be two-thirds of your gross weekly wage at the time of injury up to a maximum set by Oregon law.

Authorization to release medical records

By signing this form, you authorize health care providers and other custodians of claim records to release relevant records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

Caution against making false statements

Any person who knowingly makes any false statement or representation for the purpose of obtaining any benefit or payment commits a Class A misdemeanor under ORS 656.990(1).

Palliative care

Palliative care is care that makes you feel better, but does not cure you of an unwanted condition. You must be in the workforce, or in a vocational program, to be allowed to have palliative care.

The following are **not** palliative care:

- Prescriptions, prosthetics, braces, and doctors' appointments to monitor them
- Diagnostic services
- Life-preserving treatments
- Curative care to stabilize an acute waxing and waning of symptoms
- Services to a permanently and totally disabled worker

If you have questions about your claim that are not resolved by your employer or insurer, you may contact:

(Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

Workers Compensation Division
(División de Compensación para Trabajadores)
P.O. Box 14480, Salem, OR 97309-0405
Salem: 503-947-7585
Toll-free: 800-452-0288

Ombudsman for Injured Workers
(Ombudsman para Trabajadores Lastimados)
350 Winter Street NE, Salem, OR 97301-3878
Salem: 503-378-3351
Toll-free: 800-927-1271

A Guide for Workers Recently Hurt on the Job

How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims,"** available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
 - Authorized nurse practitioners
 - Chiropractic physicians
 - Medical doctors
 - Naturopathic physicians
 - Oral surgeons
 - Osteopathic physicians
 - Physician assistants
 - Podiatric physicians
 - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- **Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

Ombudsman for Injured Workers:

An advocate for injured workers

Toll-free: 800-927-1271

Email: oiw.questions@oregon.gov

Workers' Compensation Resolution Section

Toll-free: 800-452-0288

Email: workcomp.questions@oregon.gov

The collection and use of your Social Security number (SSN): You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for the following: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).



Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores
 (Worker's and Health Care Provider's Report for Workers' Compensation Claims)
Vea en el reverso de esta página las instrucciones en español
 (See back of this page for instructions in Spanish)

Provider instructions

<p>The worker completes the worker section of this form for the following:</p>	<p>The worker does NOT complete the worker section of this form if the provider chooses to use it for the following:</p>
<ul style="list-style-type: none"> • First report of injury or disease • Request for acceptance of a new or omitted medical condition (“Omitted” refers to a condition the worker thinks should have been included among the conditions accepted by the insurer.) If the worker checks this box, it initiates a claim processing decision by the insurer that may negatively affect the worker’s benefits. If the worker has questions, he or she may consult an attorney or the Ombudsman for Injured Workers at 1-800-927-1271 (toll-free). • Report of aggravation of original injury (“Aggravation” means the actual worsening of a compensable condition resulting from the original injury.) • Notice of change of attending physician or nurse practitioner.* This means the new provider will be primarily responsible for treatment. Being primarily responsible does NOT include: <ul style="list-style-type: none"> • <i>Treatment on an emergency basis</i> • <i>Treatment on an “on-call” basis</i> • <i>Consulting</i> • <i>Specialist care (unless the specialist assumes complete control of care)</i> • <i>Exams done at the request of the insurer or the Workers’ Compensation Division</i> <p>*Oregon nurse practitioners, chiropractic physicians, naturopathic physicians, and physician assistants must certify with the Workers’ Compensation Division to treat workers’ compensation patients and get paid.</p>	<ul style="list-style-type: none"> • Progress report • Closing report • Palliative care request (Palliative care makes the worker feel better but does not cure a condition. The worker must be in the workforce or in a vocational program to be eligible for palliative care.) The following are not palliative care: <ul style="list-style-type: none"> • <i>Prescriptions, prosthetics, braces, and doctors’ appointments to monitor them</i> • <i>Diagnostic services</i> • <i>Life-preserving treatments</i> • <i>Curative care to stabilize an acute waxing and waning of symptoms</i> • <i>Services to a permanently and totally disabled worker</i> <p>When requesting palliative care approval from the insurer, include the following in your request:</p> <ul style="list-style-type: none"> • <i>Who will provide the care</i> • <i>Modalities ordered, including frequency and duration</i> • <i>How the need for care is related to the accepted conditions</i> • <i>How the care will enable the worker to continue current work or vocational training.</i>
<p>After the worker has completed and signed Form 827s, give the worker copies of Form 827s and Form 3283s (included with this packet) immediately.</p>	<p>For these reports, you have the option of filing Form 827s, submitting chart notes, or submitting a report that includes data gathered on Form 827s.</p>

Questions about name/address of insurer: 503-947-7814 or WorkCompCoverage.wcd.oregon.gov
Questions about medical issues: Contact the medical resolution team at 503-947-7606.
For health care providers: www.OregonWCdoc.info

827s

Instrucciones para el Proveedor

<p>El trabajador debe completar esta forma en las siguientes circunstancias:</p>	<p>El trabajador NO debe completar la sección que le corresponde en este formulario para lo siguiente:</p>
<ul style="list-style-type: none"> • Primer reporte de lesión o enfermedad • Solicitud para aceptación de una condición médica nueva u omitida (“Omitida” se refiere a una condición que el trabajador piensa que debería haber sido incluida entre las condiciones aceptadas por la aseguradora.) Si el trabajador marca este casillero, inicia una decisión de procesamiento de reclamación por la aseguradora lo cual puede afectar negativamente los beneficios del trabajador. Si el trabajador tiene preguntas, él o ella pueden consultar con un abogado o con el Ombudsman para Trabajadores Lesionados llamando gratis al 1800-927-1271. • Reporte de agravación de la lesión original (“Agravación” significa el empeoramiento actual de una condición médica aceptada que resulta de la lesión original.) • Notificación de cambio de proveedor médico o enfermera(o) practicante * Esto significa que el nuevo proveedor médico será primariamente responsable por el tratamiento. Ser primariamente responsable NO incluye: <ul style="list-style-type: none"> • <i>Tratamiento en caso de emergencia</i> • <i>Tratamiento por un médico de turno (on-call)</i> • <i>Consulta médica</i> • <i>Tratamiento por un médico especialista (a menos de que el especialista asuma control completo del cuidado médico)</i> • <i>Exámenes médicos a pedido de la aseguradora o la División de Compensación para Trabajadores</i> <p>*Enfermeros practicantes de Oregon, doctores quiroprácticos, doctores naturópatas, y asistentes médicos deben tener certificación de la División de Compensación para Trabajadores para tratar pacientes con seguro de compensación para trabajadores y recibir pago.</p>	<ul style="list-style-type: none"> • Reporte de progreso • Clausura del reporte • Solicitud de cuidado paliativo (Cuidado Paliativo es un servicio médico que puede ayudar al trabajador a sentirse mejor, pero que no va a curar una condición médica. Para calificar para cuidado paliativo el trabajador debe estar trabajando, o estar en un programa vocacional.) Los siguientes no son servicios de cuidado paliativo: <ul style="list-style-type: none"> • <i>Prescripciones médicas, dispositivos prostéticos, soportes (braces), y citas médicas para control y monitoreo</i> • <i>Servicios de diagnóstico</i> • <i>Tratamientos para preservar la vida</i> • <i>Cuidados curativos para estabilizar un severo aumento y disminución de síntomas</i> • <i>Servicios provistos a un trabajador incapacitado total y permanentemente</i> <p>Para solicitar aprobación de la aseguradora para cuidado paliativo, incluya lo siguiente en su solicitud:</p> <ul style="list-style-type: none"> • <i>Quién proveerá el cuidado paliativo</i> • <i>Modalidades ordenadas, incluyendo la frecuencia y duración</i> • <i>Cómo se relaciona la necesidad del cuidado con la condición aceptada</i> • <i>Cómo el cuidado permitirá que el trabajador continúe con el trabajo actual o entrenamiento vocacional</i>
<p>Después de que el trabajador llena y firma el Formulario 827s, inmediatamente entregar al trabajador copias del Formulario 827s y el Formulario 3283s (incluido en este paquete).</p>	<p>Para estos reportes, usted tiene la opción de llenar la forma 827s, presentar notas, o reportes que incluyen información obtenida del formulario 827s.</p>

Para preguntas acerca del nombre o dirección de la aseguradora: 503-947-7814 or WorkCompCoverage.wcd.oregon.gov
Para preguntas acerca de asuntos médicos: Llame a la medical resolution team at 503-947-7606
Para proveedores del cuidado de la salud visite: www.OregonWCdoc.info

Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores
(Worker's and Health Care Provider's Report for Workers' Compensation Claims)

OPTIONAL
WCD employer no.: _____
Policy no.: _____

Note to Provider: Ask the worker to complete this form **ONLY** for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.

Trabajador o Proveedor Médico	Nombre legal del trabajador, dirección, y dirección postal (Worker's legal name, street address, and mailing address):	Idioma de preferencia (Language preference):	Masculino/Femenino (Male/female) <input type="checkbox"/> <input type="checkbox"/>	Dept. Use Ins. no.	
	Idioma de preferencia (Language preference):	Número de reclamación (si lo sabe) (Claim no. (if known)):	Fecha y hora de la lesión o enfermedad inicial (Date/time of original injury) (mes, día, año):	Nature	
	Teléfono (Phone):	Fecha de nacimiento: (Date of birth) (mes, día, año)	Ocupación (Occupation):	Último día de trabajo: (Last date worked) (mes, día, año)	Part
	Nombre y dirección del empleador al momento de la lesión original (Employer at time of original injury — name and street address):	Nombre y teléfono de la compañía de seguro de salud (Health insurance company name and phone):	Nombre y dirección de la compañía aseguradora de compensación para trabajadores (Workers' compensation insurer's name, address):		Event Source
Teléfono (Phone):				Assoc. object	

Trabajador: Marque la casilla apropiada, conteste las preguntas (si hay algunas), y firme abajo.

Trabajador (worker)	<input type="checkbox"/> Primer reporte de lesión o enfermedad ocupacional (No firme si usted no tiene la intención de registrar una reclamación.) (First report of injury or disease (Do not complete or sign if you do not intend to make a claim.))	Marque aquí si tiene más de un empleador. <input type="checkbox"/> (Check here if you have more than one job.)
	Se ha lesionado la misma parte del cuerpo anteriormente? (Have you injured the same body part before?) <input type="checkbox"/> Si <input type="checkbox"/> No Si contesto sí, cuando: (If yes, when): _____	Describe el accidente (Describe accident): _____
	<input type="checkbox"/> Solicitud para aceptación de una condición médica nueva u omitida en una reclamación existente El marcar este casillero, inicia decisiones de reclamación que pueden afectar sus beneficios. Si usted tiene preguntas consulte con su abogado o con el Ombudsman para Trabajadores Lesionados llamando gratis al 1800-927-1271 (Request for acceptance of a new or omitted medical condition on an existing claim. Checking this box initiates claim processing decisions that may affect your benefits. If you have questions, consult with your attorney or the Ombudsman for Injured Workers at 1-800-927-1271 (toll-free).) Condición (Condition): _____	
	<input type="checkbox"/> Cambio de médico primario o enfermera(o) practicante (Notice of change of attending physician or nurse practitioner) Razón para cambio (Reason for change): _____	
<input type="checkbox"/> Reporte de agravamiento de la lesión original (empeoramiento actual de la condición compensable) (Report of aggravation of original injury (actual worsening of a compensable condition))		
Al firmar este formulario, yo autorizo a los proveedores médicos y otros custodios de los expedientes de mi reclamación para proveer los expedientes médicos relevantes. Yo certifico que la información arriba provista es verdadera en el mejor de mi conocimiento y creencia. (Vea el reverso del formulario.) (By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.))		<input checked="" type="checkbox"/> Firma del trabajador (Worker's signature) _____ Fecha (Date) _____

Provider: If worker initiated this report, give worker a copy immediately.

Provider	If the worker filed this report for:	To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online: WorkCompCoverage.wcd.oregon.gov To order supplies of this form, call 503-947-7627.
	<ul style="list-style-type: none"> • First report of injury or illness – Send this form to the workers' compensation insurer within 72 hours of visit. • New or omitted medical condition – Attach chart notes that explain how this condition is causally related to the compensable injury. Send this form to the insurer within five days of visit. • Change of attending physician or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. Send this form to the insurer within five days after the change or the date of first treatment. Check the following, if applicable: <input type="checkbox"/> I request insurer to send its records. • Aggravation of original injury – Sign this form and send it to insurer within five days of visit. 	
	If filing for progress report, closing report, or palliative care request, check the appropriate box below.	
	<input type="checkbox"/> Progress report OR <input type="checkbox"/> Closing report (See instructions in Bulletin 239.) <input type="checkbox"/> Palliative care request – Complete remainder of form, except Section b. Attach a palliative care plan; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.	

Provider	a	Date/time of first treatment:	Last date treated:	Was worker hospitalized as an inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Next appointment date:	Est. length of further treatment:	If yes, name hospital:
		Current diagnosis per ICD-10-CM codes:		
	b	Has the injury or illness caused permanent impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Impairment expected <input type="checkbox"/> Unknown		Medically stationary? <input type="checkbox"/> Yes (date): _____ (Attach findings of impairment, if any.) <input type="checkbox"/> No (anticipated date): _____
		Work ability status:		
		<input type="checkbox"/> Regular work (job at injury) authorized start (date): _____		through (date, if known): _____
		<input type="checkbox"/> Modified work authorized from (date): _____		through (date, if known): _____
		<input type="checkbox"/> No work authorized from (date): _____		
	c	Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).		

Provider's name, degree, address, and phone: (print, type, or use stamp)

- Original and one copy to insurer
- Retain copy for your records
- Copies (include Form 3283s) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner

Provider's signature _____ Date _____

Notificación al trabajador (Notice to worker)

Aceptación o Rechazo de Reclamación

En la mayoría de los casos usted recibirá notificación escrita de parte de la compañía aseguradora de su empleador aceptando o rechazando su reclamación antes de 60 días. Si su empleador está asegurado por sí mismo, el aviso le será enviado por su empleador o la compañía que el empleador haya contratado para procesar sus reclamaciones de compensación para trabajadores. Si su reclamación es rechazada, se le explicará las razones del rechazo y sus derechos.

Atención médica

El proveedor médico debe avisarle si hay algún límite con los servicios médicos que él o ella pueden proveer bajo el sistema de compensación para trabajadores de Oregon.

Si su reclamación es aceptada, la aseguradora o el empleador asegurado por sí mismo pagarán todos los costos médicos relacionados con la lesión, incluyendo reembolsos por prescripciones médicas, transportación, comidas, alojamiento, y otros gastos relacionados con el tratamiento de su condición hasta por el máximo establecido. Su petición para reembolso deberá hacerse por escrito y deberá incluir copias de los recibos. Los pagos de servicios médicos no se reembolsarán antes de la aceptación de su reclamación. Si su reclamación es rechazada no se pagarán las cuentas, con algunas excepciones. Póngase en contacto con su aseguradora si tiene preguntas acerca de quien pagará sus gastos médicos.

Pagos por tiempo perdido de trabajo

Para que usted reciba pagos por el tiempo perdido de trabajo, su proveedor médico deberá notificar a la aseguradora o al empleador asegurado por sí mismo de su incapacidad para trabajar. Usted no recibirá pago por los tres primeros días calendarios que no pueda trabajar, a menos que usted esté totalmente incapacitado por 14 días calendarios consecutivos, o usted sea internado en un hospital dentro de los 14 días a partir del principio de la incapacidad total.

Usted continuará recibiendo cheques cada dos semanas durante el período de su recuperación siempre y cuando su proveedor médico verifique su incapacidad para trabajar. Estos cheques continuarán hasta que usted regrese al trabajo, o se determine que la continuación del tratamiento no mejorará su condición. Sus beneficios por tiempo perdido de trabajo serán dos tercios del pago bruto de su salario semanal al momento del accidente, hasta el máximo establecido bajo la ley de Oregon.

Autorización para compartir información sobre expedientes médicos

Al firmar este formulario, usted autoriza a los proveedores de servicios médicos y otros custodios de los expedientes de su reclamación para que compartan información pertinente con la aseguradora de compensación para trabajadores, el empleador auto-asegurado, el administrador del reclamo, y con el Departamento de Servicios para Consumidores y Negocios. Los expedientes médicos que contienen información relevante a la reclamación incluyen su historial de tratamientos anteriores por la misma condición o lesión de la misma parte del cuerpo. Una autorización de HIPPA no es requerida (45CFR 164.512(I)). Para compartir récords sobre el HIV/AIDS (SIDA), ciertos tratamientos de drogadicción o alcoholismo y otros records protegidos por la ley estatal o federal se requiere una autorización separada.

Advertencia en contra de hacer declaraciones falsas

Cualquier persona que intencionalmente hace declaraciones o representaciones falsas con el propósito de obtener cualquier beneficio o pago, está cometiendo un delito menor Clase A bajo el Estatuto Revisado de Oregon ORS 656.990(1).

Cuidado Paliativo

Cuidado Paliativo es un servicio médico que puede ayudarle a sentirse mejor, pero que no lo va a curar de su condición médica. Para calificar para cuidado paliativo usted debe estar trabajando, o en un programa vocacional.

Los siguientes **no** son considerados como cuidado paliativo:

- Prescripciones médicas, dispositivos prostéticos, soportes (braces), y citas médicas para control y monitoreo
- Servicios de diagnóstico
- Tratamientos para preservar la vida;
- Cuidados curativos para estabilizar un severo aumento y disminución de síntomas
- Servicios provistos a un trabajador incapacitado total y permanentemente

Si tiene alguna pregunta acerca de su reclamación que su empleador o compañía aseguradora no hayan podido resolver, póngase en contacto con:

Workers Compensation Division
(División de Compensación para Trabajadores)
P.O. Box 14480, Salem, OR 97309-0405
Salem: 503-947-7585
Toll-free: 800-452-0288

Ombudsman for Injured Workers
(Ombudsman para Trabajadores Lastimados)
350 Winter Street NE, Salem, OR 97301-3878
Salem: 503-378-3351
Toll-free: 800-927-1271

Una Guía para Trabajadores Lesionados Recientemente en el Trabajo

¿Cómo presento un reclamación?

- Lo más pronto posible notifique de su lesión o enfermedad en el trabajo a su empleador y a un proveedor médico **de su elección**. Su empleador no puede elegir el proveedor médico para usted.
- Pregunte a su empleador el nombre de su compañía de compensación para trabajadores.
- Complete la **Forma 801, “Reporte de Lesión o Enfermedad en el Trabajo”** la forma puede ser obtenida de su empleador. También llene la **Forma 827, “Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores”** esta forma puede ser obtenida de su proveedor médico.

¿Cómo obtengo tratamiento médico?

- Usted puede recibir tratamiento médico de un proveedor médico **de su elección**, incluyendo:
 - Enfermeras(os) practicantes autorizadas(os)
 - Médicos Quiroprácticos
 - Médicos
 - Médicos Naturopáticos
 - Cirujanos Orales
 - Médicos Osteopáticos
 - Asistentes de doctor
 - Médicos Podólogos
 - Otros proveedores médicos
- La compañía de seguros puede inscribirlo en una organización de manejo del cuidado médico a cualquier momento. Si la compañía lo hace, usted recibirá más información acerca de las opciones para tratamiento médico.

¿Existen limitaciones en mi tratamiento médico?

- **Los proveedores de cuidado médico pueden tener limitaciones en cuanto a la duración de su tratamiento y en cuanto a la autorización de pago por tiempo fuera del trabajo.** Pregunte a su proveedor médico cuales son las limitaciones que pueden aplicarse.
- **Si su reclamación es negada, es posible que usted tenga que pagar por su tratamiento médico.**

Si no puedo trabajar, ¿recibiré pagos por salario perdido?

- Es posible que no pueda trabajar debido a su lesión o enfermedad relacionada con el trabajo. Para que usted pueda recibir pago por tiempo fuera del trabajo, su proveedor médico debe enviar una autorización escrita a la aseguradora.
- Generalmente, usted no recibirá pagos por tiempo perdido por los tres primeros días calendario.
- Es posible que reciba pago por los tres primeros días calendario, si usted pierde de trabajar por 14 días consecutivos, o es hospitalizado durante un día incluyendo la noche.
- Si su reclamación es negada dentro de los primeros 14 días, no se le pagará por ningún salario perdido.
- Mantenga informado a su empleador acerca del estado de la reclamación y coopere con los esfuerzos para que regrese a trabajar en un trabajo modificado o liviano.

¿A quién puedo llamar si tengo preguntas acerca de mi reclamación?

- La compañía de seguros o su empleador pueden responder a sus preguntas.
- También puede llamar a los siguientes números:

Ombudsman para Trabajadores Lesionados:

Número gratuito: 1-800-927-1271

Email: oiw.questions@oregon.gov

Sección de Resolución de Compensación para Trabajadores:

Número gratuito: 1-800-452-0288

Email: workcomp.questions@oregon.gov

La colección y uso de su número de seguro social: Usted no necesita tener un número de seguro social para recibir beneficios de compensación para trabajadores. Si usted tiene número de seguro social, la División de Compensación para Trabajadores (WCD) del Departamento de Servicios para Consumidores y Negocios lo obtendrá de su empleador, de su aseguradora de compensación para trabajadores, o de otros recursos. WCD puede usar su número de seguro social para lo siguiente: intercambio de datos con el Departamento de Empleo, corregir identificación y procesamiento de reclamaciones, cumplimiento, investigación, administración de un programa para trabajadores lesionados, comparación de datos con otras agencias del estado para medir la efectividad de programas de WCD, actividades para prevención de lesiones, y para proveerlo a agencias federales en el programa de Medicare para su uso como está requerido por la ley federal. Las siguientes leyes autorizan a WCD a obtener su número de seguro social: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Regularly scheduled days off:	DEPT USE:
Time of injury or illness:	Time you left work:	Check here if you have more than one job:	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> M T W T F S S	Emp
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot)					Ins
					Occ
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)					Nat
					Part
					Ev
					Src
					2src

Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

Your legal name:	Language preference:	Birthdate:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Your mailing address:			
Home phone:	Work phone:	Occupation:	
Names of witnesses:			
Name and phone number of health insurance company:		Name and address of health care provider who treated you for the injury or illness you are now reporting:	
Were you hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were you treated in the emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.</p> <p>I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.</p>			
Worker signature:	Completed by (please print):	Date:	

Employer

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.

Employer legal business name:	Phone:	FEIN:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. Box):		Insurance policy no.:
Street address from which worker is/was supervised:	ZIP:	Nature of business in which worker is/was supervised:
Address where event occurred:		
Was injury caused by failure of a machine or product, or by a person other than the injured worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No		OSHA 300 log case no:
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: \$
		Date worker hired:
		If fatal, date of death:
By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.		
Employer signature:	Name and title (please print):	Date:

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Reporte de Lesión o Enfermedad en el Trabajo (Report of Job Injury or Illness) Reclamación de compensación para trabajadores (Workers' compensation claim)

Trabajador (Worker)

Para hacer una reclamación por una lesión o enfermedad ocupacional, llene la parte de esta forma que corresponde al trabajador y entreguela a su empleador. **Si usted no quiere hacer una reclamación de compensación para trabajadores con la aseguradora, no firme en la línea dejada para su firma.** Su empleador le dará una copia. (To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.)

Fecha de la lesión o enfermedad (Date of injury or illness):	Fecha que dejó el trabajo (Date you left work):	Hora que empezó a trabajar el día de la lesión (Time you began work on day of injury):	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Días que regularmente no trabaja (Regularly scheduled days off) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> M T W T F S S	DEPT USE:
Emp					
Ins					
Occ					
Nat					
Part					
Ev					
Src					
2src					

Information ABOVE this line; date of death, if death occurred; and OR-OSHA case log number must be released to an authorized worker representative upon request.

Su nombre legal (Your legal name):	Idioma de preferencia (Language preference):	Fecha de nacimiento (Birthdate):	Sexo (Gender): M <input type="checkbox"/> F <input type="checkbox"/>
Su dirección postal (Your mailing address):			
Teléfono del domicilio (Home phone):	Teléfono del trabajo (Work phone):	Ocupación (Occupation):	
Nombres de testigos (Names of witnesses):			
Nombre y número de teléfono de la compañía aseguradora de salud (Name and phone number of health insurance company):		Nombre y dirección del proveedor médico que le trató de la lesión o enfermedad que usted está ahora reportando (Name and address of health care provider who treated you for the injury or illness you are now reporting):	
¿Estuvo hospitalizado como paciente durante la noche? (Were you hospitalized overnight as an inpatient?) <input type="checkbox"/> Sí <input type="checkbox"/> No			
¿Recibió tratamiento en la sala de emergencia? (Were you treated in the emergency room?) <input type="checkbox"/> Sí <input type="checkbox"/> No			
<p>Con mi firma, estoy presentando una reclamación para beneficios de compensación para trabajadores. La información arriba provista es verdadera en el mejor de mi conocimiento y creencia. Yo autorizo a proveedores médicos y a otros custodios de los récords de mi reclamación para emitir los expedientes médicos pertinentes a la aseguradora de compensación para trabajadores, empleador asegurado por sí mismo, administrador de reclamaciones, y al Departamento para Consumidores y Negocios de Oregon. Aviso: Los expedientes médicos pertinentes incluyen registros de tratamiento anterior por las mismas condiciones o lesiones a la misma parte del cuerpo. Una autorización de HIPAA no es requerida (45 CFR 164.512(I)). Para emitir récords sobre el HIV/AIDS (SIDA), ciertos récords de tratamiento de drogadicción o alcoholismo, y otros récords protegidos por la ley estatal o federal se requiere una autorización separada.</p> <p>Yo entiendo que tengo el derecho de ver un proveedor para el cuidado de salud de mi elección sujeto a ciertas restricciones bajo ORS 656.260 y ORS 656.325.</p> <p>(By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.)</p> <p style="text-align: center;">I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.</p>			
Firma del trabajador (Worker signature):	Completada por (Completed by) Por favor escriba (please print):	Fecha (Date):	

Employador (Employer)

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.

Employer legal business name:		Phone:	FEIN:	
If worker leasing company, list client business name:			Client FEIN:	
Address of principal place of business (not P.O. Box):			Insurance policy no.:	
Street address from which worker is/was supervised:			Nature of business in which worker is/was supervised:	
ZIP:				
Address where event occurred:				
Was injury caused by failure of a machine or product, or by a person other than the injured worker? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Were other workers injured? <input type="checkbox"/> Yes <input type="checkbox"/> No			OSHA 300 log case #:	
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: \$	Date worker hired:	If fatal, date of death:
By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.				
Employer signature:		Name and title (please print):		Date:

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

801S

Technical Assistance for Employers

Department	OREGON POSTING REQUIREMENTS
About Us	POSTING REQUIREMENTS FOR OREGON EMPLOYERS
Contact Us	
Employer Seminars	
On-site Training	Oregon employers are required by a number of state and federal agencies to display a variety of workplace notices and posters. Typically, these notices must be posted in a conspicuous place, where employees may regularly view them. Employers with more than one work location are generally required to display these posters at each worksite.
Employer Handbooks & Posters	Certain posters must also be readily available for job applicants to view. These include the federal Polygraph Protection Act Notice; the federal Family and Medical Leave Act poster; the OR-OSHA Job Safety and Health poster ("It's the Law"); and the "Equal Employment Opportunity is the Law" poster.
Administrative Rules	
Oregon Revised Statutes	Small Employers (Less than 25 employees)
Government Agency Contact List	Small Oregon employers need to provide the following postings: <ol style="list-style-type: none"> 1) Oregon State Minimum Wage poster 2) Oregon OSHA poster 3) Oregon Protections for Victims of Domestic Violence, Harassment, Sexual Assault & Stalking 4) Federal Minimum Wage poster 5) "EEO is the Law" poster 6) Federal Polygraph Protection Notice 7) Federal USERRA (military rights) poster
Related Links	
Back to BOLI Home Page	
	Large Oregon Employers (25 or more employees)
	In addition to the postings listed above, large employers will need to post information regarding: <ol style="list-style-type: none"> 1) Oregon Family Leave Act 2) Federal Family and Medical Leave Act
	Agricultural Employers
	In addition to most of the postings listed for large employers, agricultural employers need to display the following additional notices: <ol style="list-style-type: none"> 1) Migrant & Seasonal Agricultural Worker Protection Act Poster 2) Field Sanitation Notice 3) "Protect yourself from pesticides" Poster 4) BOLI Notice to Agricultural Employees
	As a service to Oregon employers, BOLI's Technical Assistance for Employers program produces a number of composite posters designed to meet the specific needs of small employers, large employers as well as agricultural employers . All of our composite posters are priced between \$12.50 & \$17.50, plus shipping and handling. Previews and ordering information are available on our publications page .
	This page also provides information regarding the most commonly required posters and notices as well as contact information for the applicable regulatory agencies to obtain these postings for FREE.

DISCLAIMER:

1. Information about posters not regulated by the Bureau of Labor and Industries is provided here as a courtesy to employers. If you have questions regarding a specific poster or requirement, you must contact the issuing agency (e.g., EEOC, OR-OSHA, etc.) directly.
2. The posters listed here are general requirements only. Your industry may have additional requirements that you might be responsible to post.
3. There are many private companies across the country in the business of selling labor law posters. The Bureau of Labor and Industries is NOT associated in any way with these organizations. Before you purchase posters, be sure to contact the appropriate regulatory agency to verify that the poster is required and determine how to obtain the posters for FREE from that agency.

POSTER AND COMPLIANCE NOTICE REQUIREMENTS AND CONTACT INFORMATION

STATE REQUIRED POSTERS

- **State Minimum Wage poster** (regulated by BOLI)
Who Must Post?
All employers in Oregon, except federal government employers.
[Download](#) the English version of the **July 1, 2016 - June 30, 2017** Oregon Minimum Wage Poster.
[Download](#) the Spanish version of the **July 1, 2016 - June 30, 2017** Oregon Minimum Wage Poster.

- **Agricultural Employees: Your Rights Under Oregon's Minimum Wage Law and Child Labor Law Notice** (regulated by BOLI)
Who Must Post?
All agricultural employers in Oregon.

[Download](#) the English version of the **July 1, 2016 - June 30, 2017** Oregon Agricultural Minimum Wage Poster.
[Download](#) the Spanish version of the **July 1, 2016 - June 30, 2017** Oregon Agricultural Minimum Wage Poster.

- **Oregon Family Leave Act (OFLA) poster** (regulated by BOLI)

Who Must Post?

Employers with 25 or more employees in Oregon.

[Download](#) the English version of the **2016** Oregon Family Leave Act poster.
[Download](#) the Spanish version of the **2016** Oregon Family Leave Act poster.

- **Domestic Violence, Harassment, Sexual Assault or Stalking (DVHSAS) poster** (regulated by BOLI)

Who Must Post?

Employers with 6 or more employees in Oregon.

[Download](#) the English version of the DVHSAS poster.
[Download](#) the Spanish version of the DVHSAS poster.

- **Job Safety and Health poster, "It's the Law"** (regulated by OR-OSHA)

Who Must Post?

Employers with one or more employees.

[Download](#) the English version of the Safety and Health poster.
[Download](#) the Spanish version of the Safety and Health poster.

For additional information, contact:

Oregon Occupational Safety and Health Division (OSHA)
 Resource Center
 503-947-7447
 800-922-2689 (Oregon only)
osha.resource@state.or.us

Order forms are available at [Resource Center Website](#).

- **No Smoking poster/decal** (regulated by Department of Human Services, Health Department)

Who Must Post?

Required for all businesses under Oregon's Smokefree Workplace Law to prohibit smoking in the workplace and within 10 feet of all entrances, exits, windows and air intake vents.

[Download the Smokefree Workplace Decal \(required posting\) and other tobacco prevention materials.](#)

For additional information, contact:

Health Services
 Oregon's Smokefree Workplace
www.healthoregon.org/tobacco
 866-621-6107 Information Line
 877-270-7867 Quit Smoking Program
 877-777-6534 TTY

STATE REQUIRED COMPLIANCE NOTICES

- **Workers' Compensation Notice of Compliance** (regulated by Workers' Compensation Division of DCBS)

Who Must Post?

All employers who are required to provide workers' compensation coverage for their employees.

The Workers' Compensation Division issues this notice after it receives the proof of coverage filing from the insurer. Employers should receive this notice after purchasing workers' compensation insurance. Employers not receiving the notice or requiring a duplicate notice should contact the Workers' Compensation Division.

[Download](#) information, and order form, about the Notice of Compliance poster. You can also contact them at:

Workers' Compensation Division
 Employer Compliance
 503-947-7815
 888-877-5670
<http://www.wcd.oregon.gov>

- **Employment Insurance Notice (Form 11)** (regulated by Employment Department)

Who Must Post?

Employers with at least a \$1000 payroll in a calendar quarter and employers with one or more workers during 18 different weeks in a calendar year.

The Employment Department automatically sends this notice after an account is set up or reopened, and employers can order a duplicate if necessary. When ordering a duplicate, employers should have their business identification number ready when they call.

You will find additional information and an order form on their website at www.oregon.gov/employ/tax. You can also contact them at:

Employment Department
 Unemployment Insurance Tax Unit
 Forms Hotline: 503-947-1488, Option 3

FEDERAL POSTERS AND COMPLIANCE NOTICES

- **Federal Minimum Wage poster** (regulated by the USDOL)

The Federal Minimum Wage increased from \$6.55 per hour to \$7.25 per hour effective July 24, 2009. The current poster is available from the U.S. Department of Labor.

Who Must Post?

All employers subject to the Fair Labor Standards Act.

[Download](#) the English version of the Federal Minimum Wage poster.
[Download](#) the Spanish version of the Federal Minimum Wage poster.

- **Employee Polygraph Protection Act poster** (regulated by the USDOL)

Who Must Post?

All employers [engaged in commerce](#).

[Download](#) the English version of the Polygraph Protection Act Notice.
[Download](#) the Spanish version of the Polygraph Protection Act Notice.

- **Family and Medical Leave Poster** (regulated by the USDOL)

Who Must Post?

Employers with 50 or more workers during 20 weeks of the current or previous year.

[Download](#) the English version of the Family and Medical Leave Act poster.
[Download](#) the Spanish version of the Family and Medical Leave Act poster.

For additional information and ordering, contact:

U.S. Department of Labor
 Wage and Hour Division
www.dol.gov/whd
 866-4USADOL

- **"Equal Employment Opportunity is the Law" poster** (regulated by Equal Employment Opportunity Commission)

Who Must Post?

Employers with 15 or more employees during 20 weeks of the current or previous year (including employment agencies and labor organizations).

ADA required postings are included in this poster.

[Download](#) the Equal Employment Opportunity "EEO is the Law" poster.

For additional information and ordering, contact:

Equal Employment Opportunity Commission
www.eeoc.gov
 206-220-6883 (for information)
 800-669-3362 (to order posters)

- **The Uniformed Services Employment and Reemployment Rights Act (USERRA) poster** (regulated by the USDOL, Veteran's Employment and Training Service)

Who Must Post?

Employers are required to provide to persons entitled to the rights and benefits under USERRA, a notice of the rights, benefits and obligations of such persons and such employers under USERRA.

[Download](#) the USERRA poster. This poster is available in English only.

For additional information and ordering, contact:

U.S. Department of Labor
 Veteran's Employment and Training Service
www.dol.gov/vets
 503-947-1490
 503-731-3478

Updated June 2016

<p>OREGON.GOV</p> <ul style="list-style-type: none"> State Directories Agencies A to Z Oregon Administrative Rules Oregon Revised Statutes Oregon - an Equal Opportunity Employer About Oregon.gov 	<p>WEB SITE LINKS</p> <ul style="list-style-type: none"> Text Only Site Accessibility Oregon.gov Browser Support Privacy Policy Web Site Feedback 	<p>PDF FILE ACCESSIBILITY</p> <p>Adobe Reader, or equivalent, is required to view PDF files. Click the "Get Adobe Reader" image to get a free download of the reader from Adobe.</p> 
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