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| DCBS logo black - WCD | | | | | **Worker Leasing**  **Reinstatement Notice**  ***(Reinstates terminated Worker Leasing Notice)*** | | | | | | | | | | | | | | Internal use only  Received date:  Approved  Rejected | | | | | |
| This notice must be used to reinstate a terminated Worker Leasing Notice (Form 2465). This notice must be filed with the Oregon Workers’ Compensation Division and its insurer within 30 days after the reinstatement becomes necessary. [OAR 436-180-0110(4)]  **Please fax this notice to 503-947-7820. For other filing options, call 503-947-7675.**  If you have already removed the Notice of Compliance postings (Form 1188), you must ensure the client reposts the Notice of Compliance poster in a visible manner sufficient to inform workers about the coverage. (ORS 656.056) | | | | | | | | | | | | | | | | | | | | | | | | |
| **EFFECTIVE DATE FOR REINSTATEMENT:** | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | *(Must match effective date on the Worker Leasing Notice you wish to reinstate)* | | | | | | | | | | | | | | | | | |
| **CLIENT INFORMATION** *(provide ONLY client information in this section)* | | | | | | | | | | | | | | | | | | | | | | | | |
| Business entity legal name: | | | |  | | | | | | | | | | | | | | | | FEIN: |  | | | |
|  | | | |  | |  | | | | | | | | | | | | | |  | *(do NOT use SSNs)* | | | |
| Assumed business name (dba), if any: | | | | | |  | | | | | | | | | | | | | | | | | | |
| Client phone: | |  | | | | | | | | | Client email, if known: | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **WORKER LEASING COMPANY INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| Legal name: |  | | | | | | | | | | | | | dba | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | *(if used in Oregon)* | | | | | | | | |
| Oregon leasing license no.: | | | WLC000 | | | | | | FEIN: | | |  | | | | | |  | | | | | | |
| The worker leasing company named above, by signing this Reinstatement Notice and filing it with the Workers’ Compensation Division, hereby guarantees that it is either a self-insured employer certified under ORS 656.407, or has workers’ compensation insurance in effect to cover workers leased to the client and subject workers of the client. | | | | | | | | | | | | | | | | | | | | | | | | |
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| Authorized representative name (please print) | | | | | | | |  | | Email | | | | | | | | | | | |  | | Phone |
|  | | | | | | | | | | | | |  | |  | | | | | | | | | |
| Signature of authorized representative | | | | | | | | | | | | |  | | Date | | | | | | | | | |
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|  |  | |  | | | | | | | | | |  | |  | | | | | | | | **5361** | |
| 440-5361 (8/18/DCBS/WCD/WEB) | | | | | | | | | | | | |  | |