WORKERS' COMPENSATION NOTICE

The undersigned, an employer within the meaning of the Workers' Compensation Law of the State of Iowa, hereby gives notice to employees that the employer has secured Workers' Compensation insurance coverage for its employees in accordance with the provisions of said law, by insuring with:

_____
(Carrier Name)
PO BOX 15144
Worcester, MA 01653
1-800-628-0250

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

_____
NAME OF EMPLOYER

By: _____

Employer Representative

Dated: _____