



**Bureau of Workers'
Compensation**

30 W. Spring St.
Columbus, OH 43215

Certificate of Ohio Workers' Compensation

This certifies that the employer listed below participates in the Ohio State Insurance Fund as required by law. Therefore, the employer is entitled to the rights and benefits of the fund for the period specified. This certificate is only valid if premiums and assessments, including installments, are paid by the applicable due date. To verify coverage, visit www.bwc.ohio.gov, or call 1-800-644-6292.

This certificate must be conspicuously posted.

Policy number and employer
01476810

JOSEPH TREE SERVICE LLC
7665 FISHEL DR N
DUBLIN, OH 43016-8747

Period Specified Below
07/01/2017 to 07/01/2018



www.bwc.ohio.gov
Issued by: WC


Administrator/CEO

You can reproduce this certificate as needed.

Ohio Bureau of Workers' Compensation

Required Posting

Effective Oct. 13, 2004, Section 4123.54 of the Ohio Revised Code requires notice of rebuttable presumption. Rebuttable presumption means an employee may dispute or prove untrue the presumption (or belief) that alcohol or a controlled substance not prescribed by the employee's physician is the proximate cause (main reason) of the work-related injury.

The burden of proof is on the employee to prove the presence of alcohol or a controlled substance was not the proximate cause of the work-related injury. An employee who tests positive or refuses to submit to chemical testing may be disqualified for compensation and benefits under the Workers' Compensation Act.



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You must post this language with the Certificate of Ohio Workers' Compensation.



Statement of [Name] to [Agency]

I, [Name], do hereby certify that the foregoing is a true and correct copy of the original as shown to me by [Name] on [Date].

Signature of [Name]
[Name]

Signature of [Name]
[Name]

DATE: [Date]
TIME: [Time]
PLACE: [Location]

Special Agent in Charge
[Name]

[Name]

Statement of [Name] to [Agency]

Statement of [Name]

I, [Name], do hereby certify that the foregoing is a true and correct copy of the original as shown to me by [Name] on [Date].

The burden of proof is on the employee to show that the work-related injury or illness was caused by the work-related factors. It is the responsibility of the employee to show that the work-related factors were the primary cause of the injury or illness.

Signature of [Name]
[Name]

