Paid Leave Oregon

Verification of Serious Health Condition Form

Complete this form if you are applying for medical leave for your own serious health condition or for family leave to care for a family member with a serious health condition. Do **not** use this form if you are also submitting documentation issued directly by a health care provider.

CLAIMANT INFORMATION *(To be completed by claimant)*

First name: | Last name:

Social Security Number (SSN): _____ or
Individual Taxpayer Identification Number (ITIN):

Date of birth *(MM/DD/YYYY)*: _____ / _____ / _____

PATIENT INFORMATION *(If different from above, to be completed by claimant)*

First name: | Last name:

Relationship to claimant:

HEALTH CARE PROVIDER CERTIFICATION *(To be completed by an authorized health care provider)*

An authorized health care provider must complete and sign this section. **All sections are required unless otherwise noted.** Incomplete forms may delay the claimant's eligibility for benefits.

Briefly describe the serious health condition. Your answers should be your best estimate based on your medical knowledge, experience, and examination of the patient.

_____

_____

_____

_____

Provide the start and end dates for the serious health condition. Terms such as "unknown" or "indeterminate" will not be sufficient to determine the eligibility for Paid Leave Oregon benefits.

Start date *(MM/DD/YYYY)*: ___ /___ /_____
End date *(MM/DD/YYYY)*: ___ /___ /_____ OR ☐ Condition is chronic or permanent

Does the condition or treatment impact the patient intermittently (not every day)?

☐ Yes
☐ No

If yes, what is the maximum expected frequency of the condition or treatment?

☐ One day per week
☐ Two days per week
☐ Three days per week
☐ Four days per week
☐ Five days per week
☐ Six days per week
☐ Seven days per week

Claimant name:	SSN or ITIN:

HEALTH CARE PROVIDER CERTIFICATION *(To be completed by an authorized health care provider)*

Please provide expected leave frequency in as much detail as possible:

_____

_____

_____

_____

_____

If the serious health condition is due to pregnancy, please confirm that the patient is currently pregnant or was pregnant in the year prior to the leave start date:

☐ Yes
☐ No

HEATH CARE PROVIDER INFORMATION AND SIGNATURE

I declare that the information provided in this form is true and correct, that I am a health care provider as defined in OAR 471-070-1000(12), and that the patient's condition meets the definition of a serious health condition as defined in OAR 471-070-1000(13).

Signature:	Date: ___ /___ /_____
Name:	Title:
Certificate license number:	State or country:
License area/area of practice:	
Phone:	Email address:
Business name:	Address:

Provide all required information. Missing information can cause a delay in processing your benefit claim.

Upload this completed form to your Frances Online account at frances.oregon.gov once you have filed for benefits or mail this completed form with your Paid Leave Oregon application for benefits to:

Attn: Paid Leave Oregon
Oregon Employment Department
875 Union St NE
Salem, OR 97311

Need help?

The Oregon Employment Department (OED) is an equal opportunity agency. OED provides free help so you can use our services. Some examples are sign language and spoken-language interpreters, written materials in other languages, large print, audio, and other formats. To get help, please call 833-854-0166 (toll free). TTY users call 711. You can also send an email to paidleave@oregon.gov.

INSTRUCTIONS FOR HEALTH CARE PROVIDERS

Please review the information below to make sure you meet the definition of a health care provider before completing the form. Complete the health care provider certification and information and signature sections of this form and return it to the claimant. They will send this form to Paid Leave Oregon with their application for benefits.

Health care provider definition

OAR 471-070-1000(12) defines a health care provider as either:

1. A person who is primarily responsible for providing health care to the claimant or the family member of the claimant before or during a period of Paid Leave, who is licensed or certified to practice in accordance with the laws of the state or country in which they practice, who is performing within the scope of the person's professional license or certificate, and who is a(n):
   - Chiropractic physician (only to the extent the chiropractic physician provides treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated to exist by X-rays)
   - Dentist
   - Direct entry midwife
   - Naturopath
   - Nurse practitioner
   - Nurse practitioner specializing in nurse-midwifery
   - Optometrist
   - Physician
   - Physician's assistant
   - Psychologist
   - Registered nurse
   - Regulated social worker
2. A person who is primarily responsible for the treatment of the claimant or the family member of the claimant solely through spiritual means before or during a period of Paid Leave, including but not limited to a Christian Science practitioner.

Serious Health Condition Definition

ORS 657B.010(23) and OAR 471-070-1000(13) define a "serious health condition" as an illness, injury, impairment, or physical or mental condition of a claimant or their family member that:

- Requires inpatient care in a medical care facility such as a hospital, hospice, or residential facility such as a nursing home;
- In the medical judgement of the treating health care provider poses an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future;
- Requires constant or continuing care, including home care administered by a health care professional;
- Involves a period of incapacity. "Incapacity" is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days. A period of incapacity includes any subsequent required treatment or recovery period relating to the same condition. The incapacity must involve one of the following:
  - Two or more treatments by a health care provider;
  - One treatment plus a regimen of continuing care;

- Results in a period of incapacity or treatment for a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity, such as asthma, diabetes, or epilepsy;
- Involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as Alzheimer's Disease, a severe stroke, or terminal stages of a disease. The employee or family member must be under the continuing care of a health care provider, but need not be receiving active treatment;
- Involves multiple treatments for restorative surgery or for a condition such as chemotherapy for cancer, physical therapy for arthritis, or dialysis for kidney disease that if not treated would likely result in incapacity of more than three calendar days;
- Involves any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care; or
- Involves any period of absence from work for the donation of a body part, organ, or tissue, including preoperative or diagnostic services, surgery, post-operative treatment, and recovery.