Paid Leave Oregon

Verification of Serious Health Condition Form Instructions

INSTRUCTIONS FOR CLAIMANT

Use this form if you are:

- Applying for medical leave for your own serious health condition **OR**
- Applying for family leave to care for a family member with a serious health condition.

The patient's health care provider must sign this form. Learn what qualifies as a serious health condition and see the list of authorized health care providers in the Instructions for Health Care Provider section below.

Instructions:

- **Part A:** Complete this section with your own information as the claimant. You must include your full name.
- **Part B:** Only complete Part B if you are applying for family leave to care for a family member with a serious health condition. Complete this section with your family member's information. You must include your family member's full name and date of birth. Do not complete this section if you are applying for paid leave due to your own serious health condition.
- **Part C and D:** Provide the form and Instructions for Health Care Providers to the patient's authorized health care provider. Make sure that the authorized health care provider verifying the serious health condition completes and signs sections C and D.

Important:

- The form may not be dated and signed more than 60 days before your expected leave start date. We do not accept forms that were signed before this date.
- The form may not be altered after it was filled out and signed (for example, no strikeouts or whiteouts). We cannot accept forms that have been altered in any way. If you or your health care provider need to fill out a new form, you can find it at paidleave.oregon.gov on the Resources page.

You must provide all required information. Missing information can cause a delay in processing your benefit claim or a denial of your claim. Upload this completed form and any other documents to your Frances Online account at frances.oregon.gov or mail the completed form to the address below.

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

The fastest way to send this document is through your Frances Online account at frances.oregon.gov.

Need help?

This information is vital. 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 access.paidleave@oregon.gov.

INSTRUCTIONS FOR HEALTH CARE PROVIDERS

Claimants use this form to verify that:

- They qualify for medical leave for their own serious health condition **OR**
- They qualify for family leave to care for a family member with a serious health condition.

The patient's health care provider who is authorized to certify the claimant's or the family member's serious health condition must complete and sign this form.

To certify the serious health condition:

- Review the information below to make sure you meet the definition of an authorized health care provider and to make sure the patient's condition meets the definition of a serious health condition.
- **Only** complete **Parts C and D** of this form.
- **Part C:** Answer all questions about the patient's serious health condition and the need for leave.

  Important:

  You must include a diagnosis or a description of symptoms or required treatment sufficient to verify the condition, the approximate date the condition started or created a need for leave, and an estimate of the length of leave your patient needs. If the claimant is applying for intermittent leave, also include an estimated frequency of the condition or treatment per week.
- **Part D:** Complete this section with your information. You must also sign and date this section. By signing this form, you confirm that you are a health care provider as defined in OAR 471-070-1000, and that the information on this form is true and correct.

  Important:

  - We accept handwritten and electronic signatures. You may not sign this form more than 60 days before the claimant's expected leave start date. We cannot accept forms that were signed before this date.
  - You may **not** alter the form in any way after you fill it out and sign it (for example, no strikeouts or whiteouts). We cannot accept forms that have been altered in any way. If you need to fill out a new form, you can find it at paidleave.oregon.gov on the 'Resources' page.
  - **Return the completed and signed form 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 defines a "health care provider" as:

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
    - Naturopathic physician
    - Nurse practitioner
    - Nurse practitioner specializing in nurse-midwifery
    - Optometrist
    - Physician
    - Physician associate
    - 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:

OAR 471-070-1000 defines 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
- 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.

Paid Leave Oregon

Verification of Serious Health Condition Form

PART A: CLAIMANT INFORMATION
To be completed by claimant. **All fields are required unless otherwise noted.**

First name:	Last name:

Social Security Number (SSN): _____ (optional) or

Individual Taxpayer Identification Number (ITIN): _____ (optional)

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

Requested type of leave:	☐ Medical leave due to claimant's own serious health condition
	☐ Family leave to care for family member with serious health condition

PART B: PATIENT INFORMATION (If requesting family leave, to be completed by claimant)

First name:	Last name:
Date of birth (MM/DD/YYYY): / /	Relationship to claimant:

PART C: HEALTH CARE PROVIDER CERTIFICATION
To be completed by the patient's authorized health care provider. All fields are required unless otherwise noted.

An authorized health care provider must complete and sign this section. Incomplete or altered forms may cause a delay or a denial of the claimant's benefits.

Provide relevant medical facts sufficient to verify the serious health condition. This must include a diagnosis or a description of symptoms or required treatment for the serious health condition. Your answers should be your best estimate based on your medical knowledge, experience, and examination of the patient.

_____

_____

_____

_____

☐ Primary ICD-10 Code (optional): _____

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Claimant name:	SSN or ITIN:

PART C: HEALTH CARE PROVIDER CERTIFICATION (Continued)
To be completed by the patient's authorized health care provider. **All fields are required unless otherwise noted.**

Which of the following apply to the patient's serious health condition? Check all that apply:

- ☐ **Inpatient care:** The patient has been admitted, or is expected to be admitted, for an overnight stay in a hospital, hospice, or residential medical care facility.
- ☐ **Danger of death or terminal prognosis:** The condition poses an imminent danger of death or is terminal in prognosis.
- ☐ **Continuing care:** The condition requires constant or continuing care (for example, home care by a health care professional)
- ☐ **Incapacity plus treatment:** (for example, outpatient knee surgery, broken leg) The condition involves a period of incapacity, meaning that the patient is unable or will be unable to perform at least one essential job function or regular daily activities for more than three consecutive calendar days AND (pick one)
  - ☐ Requires two or more treatments, **OR**
  - ☐ Requires one treatment and ongoing care
- ☐ **Chronic condition:** (for example, asthma, diabetes, epilepsy) The condition requires the patient to have repeated treatment visits over an extended time. The condition may cause episodes of incapacity, rather than continuous incapacity.
- ☐ **Permanent or long-term condition:** (for example, Alzheimer's, terminal stages of cancer) Due to the condition, the patient's incapacity is permanent or long term and requires the continuing care of a health care provider even if they are not receiving active treatment.
- ☐ **Condition requiring multiple treatments:** (for example, chemotherapy, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments. If the patient did not receive treatments, it would likely result in incapacity for more than three calendar days.
- ☐ **Pregnancy and childbirth:** The patient is experiencing a period of disability due to pregnancy, childbirth, miscarriage, stillbirth, or they require a period of absence from work due to prenatal care.
- ☐ **Organ/body part/tissue donor:** The donation requires an absence from work, including for preoperative or diagnostic services, surgery or post-operative treatment and recovery.
- ☐ **None of the above:** The patient's condition does not fit any of the above serious health condition categories.

  Important: If you check this box, the patient's condition does not meet the criteria of a serious health condition and the claimant does not qualify for medical or family leave.

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Claimant name:	SSN or ITIN:

Provide the date the serious health condition started, the date it created a need for leave (if different) and an estimated end date.

Note: Terms such as "unknown" or "indeterminate" are not sufficient to determine eligibility for Paid Leave Oregon benefits.

Condition start date (MM/DD/YYYY): ____ /____ /_____

Date condition created need for leave (if different from condition start) (MM/DD/YYYY): ___ /_____ /_____

(Estimated) end date (MM/DD/YYYY): ___ /_____ /_____

If the condition is chronic or permanent, check the box below and provide a start and expected end date for the current episode of the condition.

☐ Chronic or permanent condition

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

Please provide information on the expected weekly frequency of the condition or treatment plan 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 before the leave start date:

- ☐ Yes
- ☐ No

Child's date of birth or expected delivery date (MM/DD/YYYY): ___ /___ /_____

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Claimant name:	SSN/ITIN:

PART D: HEALTH CARE PROVIDER INFORMATION AND SIGNATURE
To be completed by thepatient's authorized health care provider.

☐ I have read the definitions of health care provider and serious health condition (OAR 471-070-1000). I declare that the information provided in this form is true and correct and that I am a health care provider as defined in OAR 471-070-1000.

Health care provider signature (handwritten or electronic):	Date: ____ /___ /___

Name (first and last):	Title or specialization:
Certificate license number (optional):	U.S. state or country (for license):

Type of practice or medical specialty:

Phone:	Email address (optional):

Business name:

Address: