Oregon State University Human Resources
Protected Leave Team
Medical.leave@oregonstate.edu
236 Kerr Admin Bldg. Corvallis, OR 97331
Phone: 541-737-5946 Fax: 541-737-0553

Protected Leave Certification Fax Coversheet

Please complete the following form and return it to the Oregon State University Protected Leave team via email or fax. Our information is included below. Due to the confidential nature of this request please include the cover sheet if this is returned via fax.

From:

Sender Name: _____

Date: _____

Number of Pages (Front and back): _____

To:

Oregon State University Protected Leave

Email: medical.leave@oregonstate.edu

Fax: (541)737-0553

Confidential

Verification for Serious Health Condition Leave
Oregon State University – Oregon Paid Family and Medical Leave Plan

INSTRUCTIONS FOR EMPLOYEE

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 employee. 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. 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 Provider 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.

You must provide all required information. Missing information can cause a delay in processing your benefit claim or a denial of your claim. Send this form, along with your application for leave and any other supporting documentation to the OSU Protected Leave Team.

INSTRUCTIONS FOR HEALTH CARE PROVIDERS

Employees 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 employee'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 employee 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.
  - We accept handwritten and electronic signatures.
  - Return the completed and signed form to the Employee. The Employee will send this form to the OSU Protected Leave Team with their application for benefits

<u>Heath Care Provider definition:</u>

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 individual 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.

PART A: EMPLOYEE INFORMATION *(To be completed by employee. **All fields are required unless otherwise noted.**)*

First name:	Last name:
Employee's OSU ID#	
Date of birth *(MM/DD/YYYY)*: _____ / _____ / _____	
Requested type of leave: ☐ Medical leave due to employee'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 employee)*

First name:	Last name:
Relationship to employee:[1]	

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 employee'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)*: _____

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)*

[1] If the patient is not the employee, the patient must be a **qualifying family member of the employee**, which generally includes the following persons: a spouse, Domestic Partner, sibling, child, grandparent, grandchild, parent or an individual related to the employee by blood or Affinity whose close association with an employee is the equivalent of a family relationship.

Employee name:	

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

☐ **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 employee does not qualify for medical or family leave.

Provide the date the Serious Health Condition started, the date it created a need for leave (if different) and an estimated end date. Please note that 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

Employee name:	

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

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 prior to the leave start date:

☐ Yes
☐ No

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

PART D: HEALTH CARE PROVIDER INFORMATION AND SIGNATURE *(To be completed by the patient'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:
Type of practice or medical specialty:	
Phone:	Email address *(optional)*:
Business name:	Address *(city, state, zip code)*: