Klamath County Paid Leave
Birth Verification Form

****Only use this form if you're not submitting the child's birth certificate or other documentation issued directly by a health care provider****

Complete this form to apply for family leave to care for/bond with a child after birth.You can also use this form if you are the parent that gave birth and would like to request two additional weeks of family leave. Provide ***ALL*** required information to Klamath County Human Resources via fax (541-883-4270) or email (paidleave@klamathcounty.org).Missing information can cause a delay in processing your benefit claim.

EMPLOYEE INFORMATION INFORMATION *(To be completed by employee)*

Full Name: _____

Email Address: _____ Phone Number: (_____) _____ - _____

INSTRUCTIONS FOR HEALTH CARE PROVIDERS *(Please review information below before completing form)*

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 individual(s) listed on this form 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 (for treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated to exist by X-rays)

Dentist	NP specializing in nurse-midwifery	Psychologist
Direct entry midwife	Optometrist	Registered nurse
Naturopath	Physician	Regulated social worker
Nurse practitioner (NP)	Physician's assistant	

2. A person who is primarily responsible for the treatment of individual(s) listed on this form solely through spiritual means before or during a period of Paid Leave, including but not limited to a Christian Science practitioner.

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

An authorized health care provider must complete and sign this section. Incomplete forms may delay eligibility for benefits for the claimant.

Child's first name:	Child's last name:

Child's date of birth: _____ / _____ / _____ ***OR*** Expected delivery date : _____ / _____ / _____

Claimant's relationship to child: ◯ Parent that gave birth ◯ Parent/Guardian that did not give birth

HEALTHCARE PROVIDER INFORMATION AND SIGNATURE

Name:	Title:
Certificate license number:	State or country:
Phone: ( ) -	Email address:
Business name:	Address:

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(12).

Signature: Date: