Klamath County Paid Leave
Medical Leave/Family Leave Verification Form

**** Only complete this form if you are not submitting documentation issued directly by a health care provider****

Complete this form to apply for medical leave for your own serious health condition or for family leave to care for a family member with a serious health condition. 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.

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 listed above 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
Direct entry midwife
Naturopath
Nurse practitioner (NP)
NP 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 individual listed above 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.

PATIENT INFORMATION *(To be completed by Employee)*

Employee Name:	Patient Name:
Phone Number:( ) -	Email Address:

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 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 paid leave 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? _____ day(s)/week

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

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 de ined 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: