TheStandard®

Reset

Standard Insurance Company
866.756.8116 Tel 866.751.5174 Fax
PO Box 3877 Portland OR 97208

Applying For Oregon Paid Family And Medical Leave (OR PFML)

To Use Oregon Paid Family And Medical Leave To:
Care for a family member with a Serious Health Condition

Complete Form OR PFML-1
- ☐ Complete OR PFML-1, Part A
- ☐ Provide OR PFML-1 to employer
- ☐ Employer completes OR PFML-1, Part B and returns to you within 3 days

Complete Form OR PFML-3
- ☐ Care recipient completes OR PFML-3 and provides to Health Care Provider
- ☐ Care recipient's Health Care Provider keeps OR PFML-3

Complete Form OR PFML-4
- ☐ Complete "Employee" information at the top of OR PFML-4
- ☐ Provide OR PFML-4 to care recipient's Health Care Provider
- ☐ Care recipient's Health Care Provider completes OR PFML-4 and returns to you

Send forms and documents
- ☐ Send completed forms and supporting documentation to The Standard

Note: The Standard accepts or denies claim within 14 days once a complete claim is received.

Please keep a copy of all pages for your records.

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Request For Oregon Paid Family And Medical Leave (Form OR PFML-1) Instructions

- To request Oregon Paid Family And Medical Leave (OR PFML), the employee requesting OR PFML must complete Part A of the *Request For Oregon Paid Family And Medical Leave* (Form OR PFML-1). All items on the form are required unless noted as optional. The employee then provides the form to the employer to complete Part B.
- The employer completes Part B of the *Request For Oregon Paid Family And Medical Leave* (Form OR PFML-1) and returns it to the employee within three days.
- Additional forms are required depending on the type of leave being requested. The employee requesting leave is responsible for the completion of these forms.
- The employee submits the completed *Request For Oregon Paid Family And Medical Leave* (Form OR PFML-1) with the required additional form(s) to The Standard. The employee should retain a copy of each submitted form for their records.

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

The employee requesting OR PFML must complete all required information.

Oregon Paid Family And Medical Leave (OR PFML) Request (to be completed by the employee)

Question 9: Bond with child means to care for and bond with a Child during the first year after the Child's birth.

Adoption/Foster child means to care for Family Member to care for and bond with a Child during the first year after the placement of the Child through Foster Care or adoption.

Care for Family Member with a Serious Health Condition means Physical Assistance or Psychological Assistance as used for leave taken to care for a Family Member with a Serious Health Condition.

Safe Leave means leave for any purpose described in ORS 659A.272, including leave to:

- Seek legal or law enforcement assistance or remedies to ensure the health and safety of the Eligible Employee or the Eligible Employee's minor Child or dependent, including preparing for and participating in protective order proceedings or other civil or criminal legal proceedings related to Domestic Violence, Harassment, Sexual Assault or Stalking.
- Seek medical treatment for or to recover from injuries caused by Domestic Violence or Sexual Assault to or Harassment or Stalking of the Eligible Employee or the Eligible Employee's minor Child or dependent.
- Obtain, or to assist a minor Child or dependent in obtaining, counseling from a licensed mental health professional related to an experience of Domestic Violence, Harassment, Sexual Assault or Stalking.
- Obtain services from a victim services provider for the Eligible Employee or the Eligible Employee's minor Child or dependent.
- Relocate or take steps to secure an existing home to ensure the health and safety of the Eligible Employee or the Eligible Employee's minor Child or dependent.

Own Serious Health Condition due to Covered Employee serving as a Bone Marrow Donor

Own Serious Health Condition due to Covered Employee serving as an Organ Donor

Own Serious Health Condition due to pregnancy means any period of disability due to pregnancy, childbirth, miscarriage or stillbirth, or period of absence for prenatal care.

Own Serious Health Condition (other) means an illness, injury, impairment, or physical or mental condition of an Eligible Employee.

Question 10: Family Member means an employee's spouse, sibling, child, grandparent, grandchild, parent or an individual related to the employee by blood or affinity whose close association with an eligible employee is the equivalent of a family relationship.

Sibling means the Eligible Employee's, or the Eligible Employee's Spouse's or Domestic Partner's, sibling or stepsiblings.

Child means a biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands in *loco parentis*.

Grandchild means an Eligible Employee's, or an Eligible Employee's Spouse's or Domestic Partner's, child of the Child.

Grandparent means an Eligible Employee's, or an Eligible Employee's Spouse's or Domestic Partner's, parent of the Parent.

Parent means (a) the biological, adoptive, step or foster mother or father of the Eligible Employee; (b) a person who was a foster parent of an Eligible Employee when the Eligible Employee was a minor; (c) a person designated as the legal guardian of an Eligible Employee at the time the Eligible Employee was a minor or required a legal guardian; (d) a person with whom an Eligible Employee was or is in a relationship of in loco parentis; or (e) a parent of an Eligible Employee's Spouse or Domestic Partner.

Spouse means a person to whom an Eligible Employee is legally married.

Family Member Equivalent means an Eligible Employee's Spouse, Domestic Partner, Child, Parent, Sibling, Grandparent, Grandchild, or any individual related by blood or affinity whose close association with an Eligible Employee is the equivalent of a family relationship.

Question 11: If dates are "Continuous", the employee must provide the start and end dates of the requested OR PFML. These dates should be the actual dates that the OR PFML will begin and end. If uncertain, estimate the start and end dates and indicate "Dates are estimated". If dates are "Intermittent", enter the dates OR PFML will be taken. Please be as specific as possible. If the dates are unknown or estimated, indicate "Dates are estimated".

Intermittent Leave means leave taken in separate periods of time due to a single Qualifying Reason, rather than for one continuous period of time. Intermittent leave shall be taken in increments of no less than one Work Day and will be paid in increments that are equivalent to one Work Week.

If dates are estimated, The Standard may require you to submit a request for payment after the OR PFML day is taken. Payment for approved claims will be due 7 calendar days from the date of the claim decision.

PFML benefits will not be payable if the employee would not be performing their employment duties for reasons including but not limited to circumstances related to:

(a) An employer's business operations, such as: a lapse in seasonal operations; school break periods; or other suspensions or cessations of an employer's business operations.
(b) A period of incarceration, in which an individual is unable to perform their employment duties as a result of being an adult in custody.

Question 12: The Claimant must provide written notice to the Employer at least 30 calendar days in advance of foreseeable PFML. Verbal notice by the Claimant or a Family Member must be provided to the Employer within 24 hours of unforeseeable leave. In the context of Safe Leave, if it is not possible to provide notice in these timeframes, notice should be provided as soon as practicable. If the explanation will not fit in the space provided, enter "See Attached" and add an attachment with the explanation. Be sure to include the employee's full name and their date of birth at the top of the attachment.

Employment Information (to be completed by the employee)

Question 14: Enter the date of hire to the best of the employee's recollection. If it has been more than a year since the date of hire, entering the year in which employment started is sufficient.

Question 19: List all other income you will be receiving while on OR PFML. Include the type/name of income and how much. Example PTO from employer for $500.00 a week.

If you are pre-submitting form: Indicate if the employee is pre-submitting their OR PFML request. Pre-submitting is defined as submitting the application in advance of an upcoming qualifying event, with certain required information missing due to the information being unknown at the time of the submitting. If pre-submitting is permitted by The Standard, the missing information must be supplied as soon as it is known. Benefits cannot be determined until all of the required information is provided.

The Standard will provide the employee a notice within five days which 1) states the claim is pending; 2) identifies what information is missing; 3) instructs how to submit the missing information. **Payment for approved claims will be due 7 calendar days from the date of the claim decision.** If a Complete Application is approved more than 7 calendar days before the onset of PFML, we will commence payment of PFML Benefits as soon as PFML begins.

If The Standard does not permit pre-submitting, The Standard must return the Request for Oregon Paid Family And Medical Leave within five days to the employee with an explanation that the claim should be re-submitted when all information is available.

Employee signs and dates, before giving this form to their employer to complete Part B.

PART B - EMPLOYER INFORMATION (to be completed by the employer)

The employer of the employee requesting OR PFML must complete all information in Part B.

Question 2: If a Social Security Number is used for the Federal Employer Identification Number (FEIN), enter the Social Security Number.

Question 9: PFML benefits will not be payable if an employee is not scheduled to work on those days.

PFML benefits will not be payable if the employee would not be performing their employment duties for reasons including but not limited to circumstances related to:

(a) An employer's business operations, such as: a lapse in seasonal operations; school break periods; or other suspensions or cessations of an employer's business operations.
(b) A period of incarceration, in which an individual is unable to perform their employment duties as a result of being an adult in custody.

Question 10a: "Wage" or "wages": For the purpose of payment of benefits, means a Covered Employee's remuneration from the Employer for employment and dismissal payments.

Average Weekly Wage means the Eligible Employee's weekly Subject Wages in effect with the Employer on the day immediately preceding the date PFML begins. For Eligible Employees who are paid hourly, the Average Weekly Wage is based on the hourly pay rate multiplied by the number of hours regularly scheduled to work for the Employer per week. If the Eligible Employee does not have regular work hours, the Average Weekly Wage is based on the average number of hours worked per week for the Employer during the preceding 52 calendar weeks (or during the period of Employment with the Employer if less than 52 weeks). If an Eligible Employee is paid on an annual contract basis, the Average Weekly Wage is based on one-fifty-second ($1/52^{nd}$) of the Eligible Employee's annual contract salary with the Employer. If an Eligible Employee has multiple Employers, the Average Weekly Wage will be calculated for each employer separately.

Question 10b: An example of employees not subject to Social security and/or Medicare are certain public employees contributing to their own program and student employees of colleges and universities.

Question 11a-b: OR PFML employer reimbursement is only permitted for Wage continuation, including a paid family and/or medical leave policy of the employer, not for Accrued Paid Leave. Wage continuation is an employer's continued payment of an employee's wages during a period of PFML leave. Accrued Paid Leave is not wage continuation.

The Employer is not eligible for reimbursement for Accrued Paid Leave paid to the Eligible Employee.

Employer signs and dates, and then returns to the employee requesting OR PFML within three business days.

Be sure to complete the appropriate additional OR PFML form(s) based on the type of OR PFML leave being requested.

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Request For Oregon Paid Family And Medical Leave (Form OR PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

1. Employee's legal name (first name, middle initial, last name)	2. Other last names, if any, under which employee has worked

3. Employee's mailing address Street	City	State	Zip Code	Country (if not USA)

4. Employee's Social Security Number or TIN	5. Employee's date of birth (MM/DD/YYYY)	6. Employee's primary telephone number ( )

7. Employee's preferred email address while on OR PFML (if available)	8. Employee's gender ☐ Male ☐ Female ☐ Not designated/Other

9. Reason for OR PFML request:
Bonding: ☐ New child ☐ Adoption/Foster child
☐ Care for Family Member with a Serious Health Condition ☐ Safe Leave
☐ Own Serious Health Condition due to Covered Employee serving as a Bone Marrow Donor
☐ Own Serious Health Condition due to Covered Employee serving as an Organ Donor
☐ Own Serious Health Condition due to pregnancy ☐ Own Serious Health Condition (other)

10. The Family Member is employee's: ☐ Child ☐ Spouse or registered domestic partner ☐ Family Member Equivalent ☐ Sibling ☐ Parents and legal guardians (or spouse's parent) ☐ Grandparent ☐ Grandchild

11. Will OR PFML be for a continuous period of time and/or Intermittent?
☐ Continuous _____ / _____ / _____ _____ / _____ / _____ ☐ Dates are estimated
OR PFML start date (MM/DD/YYYY) OR PFML end date (MM/DD/YYYY)

Identify dates Intermittent OR PFML will be taken:
☐ Intermittent _____ ☐ Dates are estimated

12. Date employer was notified. If providing less than 30 day's advance notice to the employer, please explain:

Employment Information (to be completed by the employee)

13. Business name	14. Employee's date of hire (MM/DD/YYYY)	14a. Employee's last day of work (MM/DD/YYYY)

15. Has your employment ended? If so, what was your termination date?

16. Employee's work location Street address

City	State	Zip code	Country (if not U.S.A.)

17. Employer's telephone number for contact regarding this request. ( )	18. Is employee currently receiving Workers' Compensation Benefits? ☐ Yes ☐ No

19. List all other employment or Employers in last 12 months:

20. List income you will be receiving while on OR PFML, source of pay and amount.

21. Have you taken any leave in the last 12 months? ☐ Yes ☐ No	22. If yes list dates and type of leave.

Disclosure statement: Information regarding OR PFML benefits received by the employee, such as payments received and types of leave, will be provided to the employer.

Declaration and signature

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employee's signature	Date signed (MM/DD/YYYY)

☐ I am submitting this form in advance (see instructions about pre-submitting). I understand the insurance carrier will contact me to advise how to submit the required missing information.

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Request For
Oregon Paid Family And Medical Leave
(Form OR PFML-1)

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART B - EMPLOYER INFORMATION (to be completed by the employer)

1. Business's full legal name and mailing address
Southern Oregon University

Mailing address
1250 Siskiyou Blvd.

City	State	Zip code	Country (if not U.S.A.)
Ashland	**OR**	**97520**	

2. Employer's FEIN

3. Employer's EIN	4. Employer's contact name for questions related to OR PFML
47-2963287	**Michele Barlow**

5. Employer's contact telephone number	6. Employer's contact email address
(**541**) **5528119**	**barlowm@sou.edu**

7a. Employee's date of hire (MM/DD/YYYY)	7b. Employee's last day of work (MM/DD/YYYY)

8a. Employee's Typical Work Week Hours

8b. Check Days Normally Worked ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

8c. If Employee's Work Hours are rotating, indicate hours and rotation

9. Leave from work: List the dates of any scheduled breaks while the employee is on PFML leave. (example: December 18 - January 1 and March 25 - March 31 or N/A if not applicable). If dates change or are updated, inform The Standard as appropriate.

**not limited to scheduled breaks; see employer information above.*

10a. Employee's Average Weekly Wage: _____

Check one: ☐ We are a private sector employer ☐ We are a public sector government entity/employer

10b. Is employee subject to: Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No

10c. Has employee met the annual limit to Social Security max. contribution? ☐ Yes ☐ No

11a. Will any full days of Wage continuation, including the employer's own internal paid family and/or medical leave policy, be used by the employee in place of OR PFML benefits? ☐ Yes ☐ No

If so, please provide dates where full days of Wage Continuation are being paid. _____

**Wage continuation is an employer's continued payment of an employee's regular salaried wages during a period of PFML leave. Accrued Paid Leave, which includes sick leave, Oregon Paid Sick Leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off is not Wage continuation. The Employer is not eligible for reimbursement for Accrued Paid Leave paid to the Eligible Employee.*

11b. If employee received or will receive full wages while on OR PFML, will employer be requesting reimbursement? ☐ Yes ☐ No

12a. What type of paid benefits will the employee receive while on OR PFML? Include the last date through which any compensation will be paid.

12b. Is the leave request a result of employee's injury on the job? ☐ Yes ☑ No

If yes, has the employee applied for Worker's Compensation payments/benefits? ☐ Yes ☑ No

If yes, has the employee received Worker's Compensation payments/benefits? ☐ Yes ☑ No

Amount of Weekly Payment/Benefit: $_____ Effective date of benefits: _____

13. OR PFML policy number **762198**

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TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)	Employee's date of birth (MM/DD/YYYY)

PART B - EMPLOYER INFORMATION (to be completed by the employer) (*Continued)*

OR PFML insurance carrier's name and mailing address

Standard Insurance Company
PO Box 3877
Portland, OR 97208
866-751-5174 Fax

Declaration and signature

☐ I affirm the employee meets the eligibility for Oregon Paid Family And Medical Leave.

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Employer's authorized signature	Date signed (MM/DD/YYYY)

Title

Standard Insurance Company

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Oregon Paid Family And Medical Leave Release Of Personal Health Information For Family Member (Form OR PFML-3)

- If an employee is requesting Oregon Paid Family And Medical Leave (OR PFML) to care for a Family Member with a Serious Health Condition, the Family Member or an authorized representative must complete a *Release Of Personal Health Information For Family Member* (Form OR PFML-3) and submit it to their Health Care Provider, along with a copy of the *Certification For Care Of Family Member* (Form OR PFML-4).
- The *Release Of Personal Health Information For Family Member* (Form OR PFML-3) enables the Health Care Provider to complete *Certification For Care Of Family Member* (Form OR PFML-4) and release it to the employee seeking OR PFML benefits.
- Before completing and signing, the Family Member must read the *Release Of Personal Health Information For Family Member* (Form OR PFML-3) in its entirety.
- The employee requesting OR PFML submits both the *Request For Oregon Paid Family And Medical Leave* (Form OR PFML-1) and the *Certification For Care Of Family Member* (Form OR PFML-4) to their employer's OR PFML insurance carrier, for OR PFML benefit determination.

  NOTE: This form will be retained by the Health Care Provider. The employee should make a copy for their records before giving it to the Health Care Provider.

Family Member or authorized representative signs and dates.

This form is given to the Family Member's Health Care Provider along with the *Certification For Care Of Family Member* (Form OR PFML-4).

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the Family Member or authorized representative and submitted to Family Member's Health Care Provider with Form OR PFML-4)

Employee enters their name, and Family Member's name and date of birth at the top of each page.

The OR PFML insurance carrier name requested at the top of the form is the same as the OR PFML insurance carrier identified in *Request For Oregon Paid Family And Medical Leave* (Form OR PFML-1) Part B line 13.

Family Member or authorized representative must complete all applicable requested information.

If a Family Member is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the Family Member. The Health Care Provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

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Oregon Paid Family And Medical Leave Release Of Personal Health Information For Family Member (Form OR PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first name, middle initial, last name)	
Family Member's legal name	Family Member's date of birth (MM/DD/YYYY))
Relationship of Family Member to employee	If Family Member is employee's son or daughter, date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the Family Member or authorized representative and submitted to Family Member's Health Care Provider with Form OR PFML-4)

I, _____ , authorize my Health Care Provider listed on this form to
Family Member's legal name

release my personal health information to _____ and Standard Insurance Company.
Employee's legal name

Records Subject to Release: This form gives the Health Care Provider listed permission to include information from your health care records on the attached medical certification. This form gives your Health Care Provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Oregon Paid Family And Medical Leave benefits.

Duration of Revocable Release: This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the Health Care Provider listed on this form.

This form does NOT allow your Health Care Provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the Family Member or authorized representative)

Identify the Health Care Provider who is currently providing you with treatment for a condition that is subject to the employee's request for OR PFML benefits.

1. Health Care Provider's name

2. Health Care Provider's mailing address

City	State	Zip Code	Country (if not U.S.A.)

3. Health Care Provider's telephone number (provide area or country code)
( )

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Oregon Paid Family And Medical Leave Release Of Personal Health Information For Family Member (Form OR PFML-3)

TO BE COMPLETED BY THE EMPLOYEE

Employee's legal name (first legal name, middle initial, last name)	
Family Member's legal name (first name, middle initial, last name)	Family Member's date of birth (MM/DD/YYYY)

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by the Family Member or authorized representative and submitted to Family Member's Health Care Provider with Form OR PFML-4)

Family Member Information (to be completed by the Family Member or authorized representative)

4. Family Member's mailing address			
City	State	Zip Code	Country (if not U.S.A.)
5. Family Member's Social Security Number		6. Family Member's telephone number (provide area or country code) ( )	

READ AND SIGN BELOW

I have a Serious Health Condition and thereby request that the Health Care Provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition* (Form OR PFML-4) to the employee identified on Form OR PFML-4, I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting OR PFML benefits as a result of my current condition.

Family Member's signature	Date signed (MM/DD/YYYY)

Authorized representative

I, _____ , represent the Family Member in this matter as authorized by:
Print legal name

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

Authorized representative's signature	Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

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Oregon Paid Family And Medical Leave Certification For Care Of Family Member (Form OR PFML-4) Instructions

To Be Completed by Employee

INSTRUCTION to the EMPLOYEE: **The employee requesting Oregon Paid Family And Medical Leave (OR PFML) to care for Family Member with a Serious Health Condition must submit the *Certification For Care Of Family Member* (Form OR PFML-4) with *Request For Paid Family and Medical Leave* (Form OR PFML-1). Fill out the employee information of this form and give to the Health Care Provider along with *Release Of Personal Health Information For Family Member* (Form OR PFML-3). When you receive the completed *Certification For Care Of Family Member* (Form OR PFML-4) from the Health Care Provider, send the completed forms and supporting documentation to The Standard.**

Employee's Name				
Employee's Address	City	State	ZIP	Phone No.
Family Member's Name	Relationship of Family Member to employee	Family Member date of birth		
Family Member's Address	City	State	ZIP	Phone No.

To Be Completed By Health Care Provider

INSTRUCTIONS for HEALTH CARE PROVIDERS

This form is used to certify a Serious Health Condition in order to qualify for OR PFML. Qualifying Serious Health Conditions and authorized Health Care Providers are described below. Answer each question to the best of your medical knowledge, based on your examination of the Family Member.

SERIOUS HEALTH CONDITION

A "**Serious Health Condition**" is defined as an illness, injury, impairment, or physical or mental condition of 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 or inpatient substance abuse treatment center;
- 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;

Continuing Treatment by a Health Care Provider (*any one or more of the following*)

Incapacity and Treatment: Incapacity means 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; or
- one treatment plus a regimen of continuing 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.
- requires Constant or Continuing Care, including home care administered by a health care professional

Examples: the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy or childbirth:

Examples:

- Prenatal medical appointments
- Pregnancy-related complications
- Recovery from pregnancies that do not end in a live birth
- Childbirth and delivery
- Serious Health Condition resulting in incapacitation that occurs during a pregnancy or childbirth

Chronic Conditions Requiring Treatments: 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.

Examples: asthma, migraine headaches, diabetes, epilepsy

Permanent/Long-Term Conditions: involves a period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The Eligible Employee's Family Member must be under the continuing supervision of, but need not be receiving active treatment by, a Health Care Provider.

Examples: Alzheimer's, a severe stroke, or the terminal stages of a disease

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HEALTH CARE PROVIDERS

"Health Care Provider" means 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 PFML, 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:

- chiropractic physician, but 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; or
- regulated social worker

Health Care Provider also includes a person who is primarily responsible for the treatment of the Family Member of the Claimant solely through spiritual means before or during a period of Family Leave, including but not limited to a Christian Science practitioner.

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Oregon Paid Family And Medical Leave Certification For Care Of Family Member (Form OR PFML-4)

PART A: MEDICAL FACTS

1. Diagnosis _____ Primary ICD Code *(optional)* _____

   Approximate date condition commenced: _____ Probable duration of condition: _____

   Was the Family Member admitted for an inpatient care stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If so, dates of admission: _____

   _____

   Date(s) you treated the Family Member for condition: _____

   _____

   Will the Family Member need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

   Was the Family Member referred to other Health Care Provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

   If so, state the nature of such treatments and expected duration of treatment: _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected/actual delivery date: _____
3. Complications with the pregnancy or delivery? ☐ Yes ☐ No Please explain: _____

   _____

   _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the Family Member needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your Family Member's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

5. Will the Family Member be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the Family Member need care? ☐ Yes ☐ No

   Explain the care needed by the Family Member, and why such care is medically necessary: _____

   _____

   _____

6. Will the Family Member require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   _____

   Explain the care needed by the Family Member, and why such care is medically necessary: _____

   _____

   _____

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Oregon Paid Family And Medical Leave Certification For Care Of Family Member (Form OR PFML-4)

7. Will the Family Member require care on an intermittent schedule basis, including any time for recovery? ☐ Yes ☐ No

   Estimate the hours the Family Member needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the Family Member, and why such care is medically necessary: _____

   _____

   _____

8. Will the condition cause episodic flare-ups periodically preventing the Family Member from participating in normal daily activities?

   ☐ Yes ☐ No

   Based upon the Family Member's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the Family Member may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ____ day(s) per episode

   Does the Family Member need care during these flare-ups? ☐ Yes ☐ No

   Explain the care needed by the Family Member, and why such care is medically necessary _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Health Care Provider's Name		Date	
Address	City	State	ZIP
Phone No.	Fax No.		
Specialty/Type of Practice		License No.	

Declaration and signature

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Signature of Health Care Provider	Date

Print