DEPARTMENT OF ADMINISTRATIVE SERVICES
QUALIFIED REHABILITATION FACILITY PROGRAM

DOCUMENTATION OF DISABILITY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Individual's Name: _____

Social Security Number: _____

I authorize you to release the information requested below to document the conditions qualifying as a disability.

Authorized Signature: _____

Date: _____ Phone number: _____

MEDICAL PROFESSIONAL'S STATEMENT

The purpose of this form is to certify this individual as having a disability that limits the person's functional capabilities to participate in normal competitive employment. This form is part of an evaluation for qualifying this individual's participation in the QRF Program. ***ORS 279.835-850***

1. State the physical or mental disability: _____

_____

2. Duration of disability: ☐Permanent ☐Limited

3. Select the barriers to employment that so limits the person's functional capabilities that the individual is not able to engage in normal competitive employment over an extended period.

☐Mobility ☐Communication ☐Self-care ☐Self-direction ☐Work tolerance

☐Work skills ☐Interpersonal skills ☐Other (describe)_____

Oregon Administrative Rules Definition:

OAR 125-055-0005 (5) "Individual with a Disability," as defined in ORS 279.835(3), means a person who has a physical or mental impairment (a residual, limiting condition resulting from an injury, disease or congenital defect) that so limits the person's functional capabilities (such as mobility, communication, self-care, self-direction, work tolerance or work skills) that the individual is not able to engage in normal competitive employment over an extended period of time and, as a result, must rely on the provision of specialized employment opportunities.

By signature, you certify and affirm the individual meets the definitions of OAR 125-055-0005(5) for participation in the QRF Program. (ORS 279.835 –279.850)

Medical Professional licensed by:

☐ The Oregon Medical Board
☐ The Oregon State Board of Nursing as a Nurse Practitioner
☐ The Oregon Board of Naturopathic Medicine;
☐ The State Board of Psychologist Examiners.

Medical Professional's Signature:_____Date: _____

Print Signer's Name:_____Phone: _____