



OREGON DEPARTMENT OF TRANSPORTATION

HARDSHIP TRANSFER REQUEST FORM

This form is to be completed and submitted to your Region/Division Human Resources Manager for review. If approved, you will be put on a Hardship Transfer list and be considered for open positions in the location and classification approved, according to the applicable bargaining agreement and policies. Hardship transfer requests must include required verification documentation in order to be considered.

Name:	Employee ID #:
Classification	Classification #:
Title:	
Division/Section:	Crew:
Representation: <input type="checkbox"/> AEE <input type="checkbox"/> SEIU <input type="checkbox"/> Exec/Mgmt/Unrep	Location:

I am requesting a Hardship Transfer to the following location(s): (please list the specific cities/locations you wish to be transferred to)

PLEASE INDICATE THE REASON FOR YOUR REQUEST BELOW.

<input type="checkbox"/>	Serious health condition of an immediate family member that requires your care and close proximity. (Immediate family member includes: children, spouse, parents, parents in-law, brother, sister or the equivalent of each for domestic partners). Attach a Hardship Transfer Healthcare Provider Certification form verifying the illness of the family member and the need for you to care for that individual.
<input type="checkbox"/>	Move to be near to biological, adoptive or foster children. (Applies if your children have been relocated due to divorce or other situation). Attach proof of child's residence in the location listed above and/or reason for their relocation.
<input type="checkbox"/>	Personal Safety. (Applies if your own personal safety is at risk if you are not relocated). Attach proof of personal safety risk (i.e. restraining order; police report etc.)
<input type="checkbox"/>	Spouse Relocation. (Applies if the relocation was mandatory from your spouse's employer and/or there were no other options - <i>not</i> a voluntary job change/move). Attach proof of mandatory relocation and proof of spouse's current residence location.
<input type="checkbox"/>	Other: Please Explain:

EMPLOYEE SIGNATURE

Employee Signature:		Date	
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HUMAN RESOURCES USE ONLY

Request is: <input type="checkbox"/> Approved <input type="checkbox"/> Denied *	Location(s):
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*** Reason for Denial:**

HR Representative Signature:

HR Representative Printed Name:



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HARDSHIP TRANSFER REQUEST
VERIFICATION FORM

An employee has requested a Hardship Transfer to care for a seriously ill family member. The information you provide will assist us in determining the validity of the request and in determining approval status.

Employee's Name: _____

Patient's Name: _____

Patient Relationship to the employee: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN OR PRACTITIONER

1. Please check the following category that best describes the family members (patients) illness:

- | | | |
|--|--|--|
| <input type="checkbox"/> 1 Hospital care | <input type="checkbox"/> 3 Chronic requiring treatment | <input type="checkbox"/> 6 Poses imminent danger of death, terminal in prognosis |
| <input type="checkbox"/> 2 Absence+treatment | <input type="checkbox"/> 4 Perm/ long-term requiring treatment | |
| | <input type="checkbox"/> 5 Multiple treatments (non-chronic) or requires constant care | |

2. Approximate date condition began: ___/___/___ Duration of condition: from ___/___/___ to ___/___/___

3. Is the patient presently incapacitated ("incapacitated" for these purposes is defined to mean inability to work or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom)?

- Yes – please indicate an estimated date of recovery if any: ___/___/___
- No

4. Does the patient's illness require a "caregiver" and/or is it necessary for the ODOT employee to assist the patient with activities that require them to live in close proximity to the patient?

Yes (Please describe the type of care the patient requires from the employee.):

 No

Physician/Practitioner Signature:			
Physician/Practitioner Printed Name:		Date:	
Type of Practice/Specialized Field:			
Telephone Number:			