



DEPARTMENT OF ADMINISTRATIVE SERVICES
QUALIFIED REHABILITATION FACILITY PROGRAM
DOCUMENTATION OF DISABILITY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO: _____

QRF Organization

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

Medical Professional's Signature: _____ Date: _____

Print Signer's Name: _____ Phone: _____