



# HARDSHIP TRANSFER MEDICAL VERIFICATION FORM

(This form is completed by the Physician)

## OREGON DEPARTMENT OF CORRECTIONS HARDSHIP TRANSFER VERIFICATION FORM

An employee has requested a Hardship Transfer to manage their own serious health condition or 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's Relationship to Employee: \_\_\_\_\_

### TO BE COMPLETED BY ATTENDING PHYSICIAN OR PRACTITIONER

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

- Hospital Care
- Absence plus treatment
- Poses imminent danger of death. Terminal in prognosis
- Multiple treatments (non-chronic) or requires constant care
- Chronic requiring treatment
- Perm/long-term requiring treatment

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 a serious health condition, treatment of, or recovery from.)

- 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 Dept of Corrections 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: \_\_\_\_\_

Type of Practice/Specialized Field: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_