Oregon Department of Transportation

Health Care Provider Certificate for Hardship Donations

Health Care Provider Name:

_____

Address:

_____

_____

_____

Regarding:

_____

(EMPLOYEE / PATIENT NAME)

The employee named above has requested Hardship Leave Donations. In order for the Department of Transportation to provide our employees with this leave, it is necessary that we receive certification from an attending health care provider that a medical need exists for either the employee or a family member requiring the employee's attendance.

Please provide the following information:

Can you verify that this employee/patient or one of his/her family members has a health condition or injury which is expected to continue for at least 30 days?
Please circle one: **YES** **NO**

Please provide a short statement regarding the nature of the employee's or his/her family member's medical situation:

_____

_____

State the approximate date the condition started:

_____

State the probable duration of the illness or injury*:

_____

_____

Health Care Provider Signature Date

*In order to approve our employee's request for this type of leave an approximate duration date must be designated. Without this information, the leave request can not be approved.

Return form by mail or Fax to: **Oregon Department of Transportation**
Human Resources
355 Capitol St. NE, Rom 102
Salem, OR 97301

Fax: 503.986.389