OREGON DEPARTMENT OF TRANSPORTATION

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:

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

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:			