

Qualifying Event for Serious Medical Condition

The Graduate Student Assistance Fund Serious Medical Condition award up to \$1,000 requires the following documentation:

If you are applying on behalf of your own serious health condition:	
Information Verified	Documentation Accepted
Serious Medical Condition	Certification for Medical Condition form by a licensed healthcare practitioner -or- documentation of approved leave related to the serious condition under Paid Leave Oregon

If you are applying for the care of a spouse (or equivalent under Oregon law), registered domestic partner, child, or parent:		
Information Verified	Documentation Accepted	
Medical Condition	Certification for Medical Condition form by a licensed healthcare practitioner	
Relationship to Person Experiencing Serious Medical Condition	Choose one	
	Please upload this documentation along with the signed Certification form	
	Spouse	Marriage certificate
	Registered domestic partner	Notarized Declaration of Registered Domestic Partnership
	Child	Birth certificate; adoption certificate; foster care placement letter with name of parent/guardian, birth date
	Parent	Your birth certificate, adoption certificate, or foster care placement letter with your name and your parent/guardian's name

Certification for Serious Medical Condition

This form is used to verify a graduate student's request for a financial award related to care for their own serious medical condition -or- the care of spouse (or equivalent under Oregon law), registered domestic partner, child (18 years or younger), or parent who is experiencing a serious medical condition.

To be completed by a licensed healthcare practitioner:

Patient First and Last Name _____

Is the patient experiencing a serious medical condition?

☐

Yes

☐

No

The definition of a serious medical or health condition may include:

- Inpatient or hospice care
- Long-term conditions requiring ongoing treatment
- Multiple treatments
- Incapacity and continuing treatment

Date of Discovery or Diagnosis _____

Date of Office Visit (related to the
condition above) _____

Provider First and Last Name _____

Provider Title _____

Name of Practice or Organization _____

Type of Practice or Specialization _____

Address _____

Phone Number _____

Signature of Provider _____

Date Signed _____