

# Qualifying Event for Care for Medical Condition

The Graduate Student Assistance Fund Care for Medical Condition award up to \$300 requires the following documentation:

If you are applying on behalf of your own serious health condition:		
Information Verified	Documentation Accepted	Alternative Documentation Accepted
Medical Condition	Certification for Medical Condition form by a licensed healthcare practitioner	If your medical condition is linked to services you receive from the Accessible Education Center ( <a href="#">AEC</a> ) and give permission for AEC to disclose relevant medical information in your application, the Division of Graduate Studies can verify your eligibility with their office directly.

If you are applying for the care of a spouse (or equivalent under Oregon law), registered domestic partner, child (18 years or younger), 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 <span style="float: right;">Please upload this documentation along with the signed Certification form</span>	
	Child up to 18 years old	Birth certificate; adoption certificate; foster care placement letter with name of parent/guardian, birth date
	Spouse	Marriage certificate
	Registered Domestic Partner	Notarized Declaration of Registered Domestic Partnership
	Unregistered Domestic Partner	<ul style="list-style-type: none"> <li>State ID, driver’s license, or equivalent that shows the same address or residence</li> <li>Lease agreement, mortgage statement, bank statement, vehicle registration, car insurance, or utility bill that includes both student and partners’ names and the same address or residence</li> </ul>
Parent	Your birth certificate, adoption certificate, or foster care placement letter with your name and your parent/guardian’s name	

# Certification for 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 or a condition such as surgery, hospitalization, chronic illness, disability, injury, etc. that might hinder the ability to care for oneself? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, please describe the medical condition. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Discovery or Diagnosis \_\_\_\_\_

Date of Office Visit (related to the medical condition above) \_\_\_\_\_

Provider First and Last Name \_\_\_\_\_

Provider Title \_\_\_\_\_

Name of Practice \_\_\_\_\_

Type of Practice or Specialization \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

Signature of Provider \_\_\_\_\_

Date Signed \_\_\_\_\_