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CHAPTER 848
OREGON BOARD OF PHYSICAL THERAPY

FILING CAPTION: Revisions and Clarifications to Minimum Standards for Physical Therapy Practice and Records.

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RULES:
848-040-0100, 848-040-0105, 848-040-0110, 848-040-0120, 848-040-0125, 848-040-0130, 848-040-0135, 848-040-0140, 848-040-0145, 848-040-0147, 848-040-0150, 848-040-0155, 848-040-0160

AMEND: 848-040-0100

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Adding definition for evidence-based practice and removing outdated definitions related to records.

CHANGES TO RULE:

848-040-0100
Definitions ¶

As used in this Division:¶
(1) "Authentication" means the process by which the licensee reviews and validates the accuracy of the record entry. By authenticating a record entry, the licensee certifies that the services described were performed by the authenticating licensee or performed by a person under that licensee's supervision.¶
(2) "Evidence-based practice" means the application of (1) best available research evidence, (2) clinical expertise, and (3) specific consideration of each patients' characteristics, values, and circumstances, to inform care.¶
(3) "IDEA" means Individuals with Disabilities Education Improvement Act.¶
(~~3~~4) "IEP" means an Individualized Education Plan developed for a child/student qualified under the IDEA program.¶
(~~4~~5) "IFSP" means an Individualized Family Services Plan developed for a child qualified under the IDEA Early Intervention Program.¶
(~~5~~6) "Licensee" means a physical therapist or a physical therapist assistant and includes a temporary permit holder and an Oregon Compact Privilege holder.¶
(~~6~~7) "Patient" means one who seeks and receives physical therapy services. For purposes of these rules, patient may include a person receiving services in a home, by telehealth or clinical setting, a student in a school setting, a child receiving early intervention services, a resident of a care facility, or an animal.¶
~~(7) "Permanent Record" means the final version of the record of each evaluation, reassessment or treatment provided to a patient which becomes part of the patient's medical record.¶~~
(8) "Physical therapy intervention" means a treatment or procedure and includes but is not limited to: therapeutic exercise; gait and locomotion training; neuromuscular reeducation; manual therapy techniques (including manual

lymphatic drainage, manual traction, connective tissue and therapeutic massage, mobilization/manipulation of soft tissue or spinal or peripheral joints, and passive range of motion); functional training related to physical movement and mobility in self-care and home management (including activities of daily living (ADL) and instrumental activities of daily living (IADL)); functional training related to physical movement and mobility in work (job/school/play), community, and leisure integration or reintegration (including IADL, work hardening, and work conditioning); prescription, application, and, as appropriate, fabrication of devices and equipment (assistive, adaptive, orthotic, protective, or supportive); airway clearance techniques; integumentary repair and protective techniques; electrotherapeutic modalities; physical agents and mechanical modalities; and patient related instruction and education.¶
(9) "Plan of care" means a written course of physical therapy treatment established by a physical therapist following an initial evaluation which integrates the evaluation data collected to determine the degree to which physical therapy interventions are likely to achieve anticipated goals and expected outcomes.¶
(10)~~ "Record" means a written or electronic account of the detailed information gathered from each evaluation, reassessment, and the treatment provided to a patient. This documentation may be used to create the separate, permanent record, or it may serve as the permanent record.¶~~
~~(11)~~ "Student" means a child ages 3 to 21 who are enrolled in an educational institution and who qualifies for services under IDEA or Section 504 of the Rehabilitation Act, or other designated plan of care, or child ages 0-2 who qualifies under the IDEA Early Intervention Program.¶
(1~~2~~1) "Student PT or Student PTA" means a person enrolled in a CAPTE accredited physical therapist or physical therapist assistant program and who is providing patient care as part of the required clinical education.¶
(1~~3~~2) "Telehealth service" means a physical therapy intervention, including assessment or consultation, that can be safely and effectively provided using synchronous two-way interactive video conferencing, or asynchronous video communication, in accordance with generally accepted healthcare practices and standards. For purposes of these rules, "telehealth service" also means, or may be referred to, as "telepractice, teletherapy, or telerehab."¶
(1~~4~~3) "Domiciled" a person is domiciled in this state if the person's place of abode is in the state and the person intends to remain in the state or, if absent, to return to it.
Statutory/Other Authority: ORS 688.160, ORS 688.240
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0105

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Clarifying competent practice.

CHANGES TO RULE:

848-040-0105
General Standards for Practice ¶

(1) Licensees shall practice competently. A licensee practices competently when the~~ licensee uses that~~y apply evidence-based practice with the appropriate knowledge, skill and degree of care~~, skill~~ and diligence that would be used by a reasonable, careful and prudent licensee under the same or similar circumstances.¶
(2) A physical therapist must immediately refer a patient to an appropriate medical provider if signs or symptoms are present that require treatment or diagnosis by such provider or for which physical therapy is contraindicated or if treatment for the signs or symptoms is outside the knowledge of the physical therapist or scope of practice of physical therapy.¶
(3) A licensee shall not delegate to another person any task that the person is not legally authorized to perform or is not qualified by training and experience to perform.¶
(4) A licensee shall not provide treatment intervention that is not warranted by the patient's condition.¶
(5) A licensee shall respect the privacy and dignity of the patient in all aspects of practice.¶
(6) A licensee shall comply with the laws and rules governing the use and disclosure of a patient's protected health information as provided in ORS 192.553-192.581.¶
(7) A licensee shall comply with the provisions of ORS 688.135(3) by displaying a copy of their current license in their place(s) of employment in a location accessible to public view, or by making a paper or electronic copy readily available upon request, or by displaying an electronic verification of current status from the Board's website.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0110

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Clarifying meaning of documentation and record.

CHANGES TO RULE:

848-040-0110
General Standards for Record Keeping ¶

(1) The licensee who performs the physical therapy service shall prepare a complete and accurate record for every patient, regardless of whether compensation is given or received for the therapy services and regardless of whether the patient receives treatment pursuant to a referral or is self-referred.¶
(2) ~~A record~~Sufficient written documentation shall be prepared on the same date a physical therapy service is provided.¶
(3) ~~The permanent record shall contain information for every physical therapy service provided, the date the service was provided and the date the entry was made in the record. The perman~~If the written documentation of the service provided described in (2) is made outside of the patient's record, such as but not limited to, when handwritten notes are not documented directly in the electronic record, or when the encounter is outside the clinic where the patient's record ~~of a physical therapy service shall be prepared wi~~is stored, that written documentation must be added to the patient's record in a timely manner appropriate for the care setting, but never longer th~~i~~an seven calendar days ~~o~~from the date the service was provided. Such entries must include date of entry if different than date of service.¶
(4) The licensee who performs the physical therapy service shall authenticate the ~~permanent record~~documentation of the service that was performed. Authentication may be made by written signature or by electronic means. If authentication is by electronic means, the licensee shall not permit another person to use the licensee's password to authenticate the entry. Authentication may not be accomplished by the use of initials, except when a~~ record~~n entry identifying an error is authenticated. A rubber stamp may not be used to authenticate any entry in a patient record.¶
(5) Non-licensees, including physical therapist aides, may prepare physical therapy treatment-related entries for the ~~permanent~~ patient record for authentication by the treating licensee. The requirement for authentication shall not apply to records not related to physical therapy treatment.¶
(6) ~~Either the permanent record or a record prepared on the date of service~~All documentation shall be readily accessible to a licensee prior to when that licensee provides subsequent treatment to the patient. "Readily accessible" means the authenticating licensee is able to produce the record immediately upon request.¶
(7) All entries shall be legible and permanent handwritten records shall be in ink.¶
(8) Abbreviations may be used if they are ~~recogniz~~defined ~~st~~and~~ard physical therapy abbreviations or are approved for use~~ accessible to all individuals accessing the ~~specific practice setting~~patient's record.¶
(9) When an error in the p~~erman~~atient record is discovered, the error shall be identified and corrected. The erroneous entry shall be crossed out, dated and initialed or otherwise identified as an error in an equivalent written manner by the author of the erroneous entry.¶
(10) Late entries or additions to entries in the p~~erman~~atient record shall be documented when the omission is discovered with the following written at the beginning of the entry: "late entry for (date)" or "addendum for (date)" and authenticated;¶
(11) Treatment provided by a student physical therapist (SPT) may be documented either by the SPT or by the supervising therapist. Documentation by a SPT shall be signed by the student and authenticated by a supervising physical therapist.¶
(12) Treatment provided by a student physical therapist assistant (SPTA) may be documented either by the SPTA or by the supervising therapist or physical therapist assistant. Documentation by a SPTA shall be signed by the student and authenticated by a supervising physical therapist or supervising physical therapist assistant.¶
(13) Documentation by a person who holds a physical therapist temporary permit issued under OAR 848-010-0026(1)(a) shall be authenticated by the permit holder and by a supervising physical therapist.¶
(14) Documentation by a person who holds a physical therapist assistant temporary permit issued under OAR 848-010-0026(1)(a) shall be authenticated by the permit holder and by a supervising physical therapist or supervising physical therapist assistant.¶
(15) For purposes of the Board's enforcement of these rules, patient records shall be kept for a minimum of seven years measured from the date of the most recent entry.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0120

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Clarifying requirements for documentation of oral referral.

CHANGES TO RULE:

848-040-0120
Standards For Record Of Authorization ¶

(1) A written referral received from a provider identified in ORS 688.132(1) shall be included in the patient record. In order to qualify as an authorization, a written referral must include, at a minimum, the name of the patient, the name of the provider, authentication by the provider and the date of the referral.¶
(2) An oral referral received from a provider identified in ORS 688.132(1) shall be documented in the patient record. Documentation shall include the name of the provider; the name of the person communicating the referral~~, if not the provider~~; the date the referral was received; the name of the person to whom the oral referral was communicated; the name of the patient; and a description of the referral~~, including diagnosis, frequency and duration, if specified~~. A non-licensee may accept and document an oral referral.¶
(3) ~~A~~If an oral referral ~~must be followed-up with a written referral from the provider~~is received a written referral must be requested from the provider. Documentation of the request shall include the date request was made and name of person making request. The written request received subsequent to an oral referral shall be included in the patient record when received.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0125

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Minor clarifications to standards for initiation of physical therapy

CHANGES TO RULE:

848-040-0125
Standards For Initiation Of Physical Therapy ¶

(1) Except as provided in subsection (5) of this section, prior to initiating the first physical therapy treatment, a physical therapist shall perform an initial evaluation of each patient and determine a plan of care as provided in OAR 848-040-0135.¶
(2) In the course of performing an initial evaluation the physical therapist shall examine the patient, obtain a history, perform relevant system reviews, assess the patient's functional status, select and administer specific tests and measurements and formulate clinical judgments regarding the patient. A physical therapist may incorporate by reference medical history or system review information about the patient prepared by another ~~licensed health care~~ provider and available in the p~~hysical therapy treatm~~atient record, IEP, IFSP or other designated plan of care.¶
(3) For purposes of subsection (1) of this section, a physical therapist shall perform a separate initial evaluation under the following circumstances:¶
(a) The patient is returning to care after being discharged from therapy;¶
(b) The patient ~~i~~has n~~ew to an inp~~ot received physical therapy treat~~i~~ment ~~or outpatient~~at the clinic, facility or patient home ~~health agency~~for the current episode of care; or¶
(c) A current patient presents with a new diagnosis for an unrelated condition or body part.¶
(4) Only a physical therapist may perform an initial evaluation. A physical therapist shall not delegate the performance of an initial evaluation to a physical therapist assistant or to an aide.¶
(5) Under circumstances or situations where a physical therapist is called upon to provide immediate minimal or basic treatment to a person participating in an athletic activity or event, the physical therapist shall examine the person by performing tests and measurements appropriate to the circumstances, assess the person's condition, formulate clinical judgments, and determine the immediate care to be provided. Documentation under this subsection shall include, at a minimum, the person's name, age if available, a brief description of the injury or condition, and disposition or treatment, including recommendation for additional or alternative care. Neither a physical therapy plan of care nor a discharge summary is required in these circumstances.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0130

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Amending to simplify and clarify standards.

CHANGES TO RULE:

848-040-0130
Standards For The Documentation Of An Initial Evaluation ¶

Except as provided in subsection (5) of OAR 848-040-0125, the ~~record of the~~physical therapist who performs an initial evaluation shall ~~include~~document:¶
(1) ~~P~~The patient's ~~full name, age and sex;¶~~
~~(2) Identification number, if appropriate~~identifying information;¶
(~~3~~2) ~~Referral source, including patient self-referral;¶~~
~~(4) Pertinent medical or physical therapy diagnoses, medications if not otherwise accessible in another part of the patient's medical record, history of presenting problem and current complaints and symptoms, including onset date;¶~~
~~(5) Prior or concurrent services related to the provision of physical therapy services;¶~~
~~(6) Any co-existing condition that affects either the goal~~The patient's reason for seeking physical therapy services;¶
(3) The patients' relevant medical diagnoses or conditions;¶
(4) The patient's signs and symptoms;¶
(5) Objective data from tests or measurements;¶
(6) The physical therapist's interpretation of the results o~~r~~f the ~~plan of care;¶~~
~~(7) Precautions, special problems and contraindic~~examinations;¶
(~~8~~7) ~~Subjective information (patient's knowledge of problem);¶~~
~~(9) Patient's goals (with family input or family goals, if appropriate). Goals may be as¶~~
~~provided in an applicable IEP, IFSP, or other designated~~Clinical rationale for therapeutic intervention;¶
(8) The plan of care~~;~~ a~~nd¶~~
~~(10) Appropriate objective testing results, including but not limited to:¶~~
~~(a) Critical behavior/cognitive status;¶~~
~~(b) Physical status (e.g., pain, neurological, musculoskeletal, cardiovascular, pulmonary)~~s described in OAR 848-040-0140, and;¶
(~~c~~9) ~~Functional status (for Activities of Daily Living, work, school, home or sport performance); and¶~~
~~(d) Interpretation of evaluation result~~The patient's prognosis.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0135

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Amending to clarify language relating to standards for plan of care.

CHANGES TO RULE:

848-040-0135
Standards For The Plan of Care ¶

(1) Prior to initiation of treatment, a physical therapy plan of care for the patient shall be determined by a physical therapist. As appropriate, a plan of care may include the IFSP, or, in a school setting, a plan of care may include the IEP for a student, or other designated plan of care.¶
(2) Only a physical therapist may develop a plan of care. A physical therapist shall not delegate the development of the plan of care to a physical therapist assistant or to an aide.¶
(3) A physical therapist shall identify appropriate treatment tasks to be delegated to a physical therapist assistant or aide.¶
(4) Only a physical therapist may modify a plan of care. However, a physical therapist assistant may make recommendations to the physical therapist ~~in ~~regard~~s to~~ing revision of the plan of care for a patient for whom the physical therapist assistant has been providing treatment.¶
(5) A physical therapist shall reexamine the patient and make modifications to the plan of care any time there are significant changes in the patient's condition or status that would affect the physical therapy goals.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0140

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Clarifying documentation requirements to remove outdated record reference.

CHANGES TO RULE:

848-040-0140
Standards For The Documentation Of The Plan Of Care ¶

(1) The ~~permanent record~~documentation of the plan of care shall include:¶
(a) Objectively measurable treatment goals that incorporate the patient's goals;¶
(b) Proposed t~~reatment~~herapeutic interventions to accomplish the goals; and¶
(c) Proposed frequency and duration of treatment or number of visits.¶
(2) The ~~permanent record~~documentation of the plan of care shall be authenticated and dated by the physical therapist who developed the plan.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0145

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Amending to align with other clarifications related to reexamination.

CHANGES TO RULE:

848-040-0145
Standards For Providing Treatment ¶

(1) A licensee shall not permit an aide to administer a task that is prohibited under OAR 848-020-0060, and shall not permit an aide to administer a non-prohibited procedure or modality to a patient unless a licensee has previously administered that procedure or modality to the patient.¶
(2) A physical therapist or physical therapist assistant shall perform, or attempt to perform physical therapy interventions only with qualified education and experiencehen competent in that intervention.¶
(3) Except as provided in OAR 848-015-0020(6), a physical therapist or physical therapist assistant shall not continue to provide treatment to a patient unless a reassessmpatient has been performed whenreexamined by a physical therapist as required by 848-040-0155. However, a physical therapist assistant may provide treatment on the day a reassessmentexamination is required, so long as during that treatment day a physical therapist performs the required reassessmreexamines the patient.¶
(4) A physical therapist or physical therapist assistant shall provide treatment in accordance with the provisions of OAR 848-040-0105.¶
(5) At all times there shall be a physical therapist supervising the treatment provided by a physical therapist assistant as provided in OAR 848-015-0020(2) or an aide as provided in 848-020-0000(5). "Supervising physical therapist" means either the last physical therapist to see the patient, or the physical therapist designated as in-charge of the patient on the day the patient is being treated.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0147

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Amending to remove excess language.

CHANGES TO RULE:

848-040-0147
Standards for Treatment by a Student PT or Student PTA ¶

(1) A physical therapist may allow a student physical therapist (SPT) or student physical therapist assistant (SPTA), as defined in OAR 848-040-0100(12), to provide treatment consistent with the individual student's education, experience and skills.¶
(2) A physical therapist assistant may allow an SPTA to provide treatment consistent with the individual student's education, experience and skills.¶
(3) At all times, a supervising physical therapist must provide on-site supervision of an SPT or SPTA who provides treatment to a patient.¶
(4) For purposes of this rule "supervising physical therapist" means the physical therapist who is responsible for that patient's treatment on the day the SPT or SPTA provides treatment.¶
(5) For purposes of this rule "on-site supervision" means that at all times the supervising physical therapist is in the same building and immediately available to provide in person direction, assistance, advice or instruction to the student.¶
(6) A physical therapist may delegate supervision of an SPTA to a physical therapist assistant and the provision of subsections (3), (4) and (5) of this rule shall apply to the physical therapist assistant.¶
(7) Documentation by a ~~student physical therapist (~~SPT~~)~~ shall be signed by the student and authenticated by a supervising physical therapist on the same day. Documentation by a ~~student physical therapist assistant (~~SPTA~~)~~ shall be signed by the student and authenticated by a supervising physical therapist or supervising physical therapist assistant on the same day. A SPT's documentation must be completed pursuant to OAR 848-040-0110.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010

AMEND: 848-040-0150

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Amending to simplify and clarify documentation requirements.

CHANGES TO RULE:

848-040-0150
Standards For The Documentation of Treatment Provided ¶

(1) Except as provided in subsection (5) of OAR 848-040-0125, ~~the record~~documentation of treatment for each patient visit shall include at a minimum:¶
(a) Subjective status of patient;¶
(b) Specific t~~reatment~~herapeutic interventions, information, and education provided;¶
(c) Objective data from tests and measurements conducted;¶
(d) Assessment of the patient's response to t~~reatment, including but not limited to:¶~~
~~(A) Patient status, progression or regression;¶~~
~~(B) Changes in objective and measurable findings as they relate to existing goals;~~herapeutic interventions, and,¶
(~~C~~e) ~~Adverse reactions to treatment.¶~~
~~(e) Changes in the plan of care.¶~~
~~(2) When treatment is provided by a physical therapist assistant, the physical therapist assistant shall record and authenticate those services~~Updates to the plan of care.¶
(2) A supervising physical therapist may document treatment provided by a physical therapist assistant. If the supervising physical therapist records and authenticates treatment provided by the physical therapist assistant, the physical therapist shall document which ~~service~~treatment interventions were provided that day by the physical therapist assistant. When treatment is provided or assisted by an aide, the aide may only document~~ in the patient record[s]~~ objective information about the treatment intervention provided by the aide. When a supervising physical therapist assistant or supervising physical therapist authenticates treatment provided by an aide, the therapist shall document which ~~service~~treatment interventions were provided that day by the aide.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0155

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Amending to clarify language and allow for flexible periodic examination within certain conditions.

CHANGES TO RULE:

848-040-0155
Standards For ~~Performing a Reassessment~~Reexamination ¶

(1) A physical therapist shall ~~perform a reassessment of a patient~~reexamine a patient periodically as follows:¶
(a) Anytime there are significant changes in the patient's condition or status that would result in a change in the goals or the plan of care;¶
(b) When ~~a physical therapist has not directly treated the patient within the previous 30 days;¶~~
~~(c) At every visit when~~ the interval since a patient's last visit is 30 days or longer; or¶
(~~d~~c) At least every 60 school days if the patient is a student who is being treated in an educational setting and a physical therapist has not treated the student within 60 school days, or at every visit if the student is seen less frequently.¶
(2) In the course of ~~perform~~conducting the re~~assessment~~examination, a physical therapist shall personally examine the patient, assess the patient's ~~functional status, select specific tests and measurements, formulate clinical judgments regarding the patient~~status, and update the goals or plan of care.¶
(3) Only a physical therapist may perform a re~~assessment~~examination. A physical therapist shall not delegate the ~~performance of a reassessment~~reexamination to a physical therapist assistant or to an aide. However, a physical therapist may delegate to a physical therapist assistant the gathering of data for a re~~assessment~~examination as provided in OAR 848-015-0030(1)(b)¶
(4) If a physical therapist assistant is providing care to a patient and identifies a plateau or change in patient status that may result in the need for a change in the goals or the plan of care, the physical therapist assistant must consult with a physical therapist, who must determine if a reexamination is required.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210

AMEND: 848-040-0160

NOTICE FILED DATE: 11/26/2024

RULE SUMMARY: Amending to use new language and simplify requirements.

CHANGES TO RULE:

848-040-0160
Standards For The Documentation of a Re~~assessment~~examination ¶

(1) When a physical therapist is required to perform a re~~assessment~~examination under OAR 848-040-0155, the ~~record of the reassessment~~documentation of the reexamination shall include at a minimum:¶
(a) Subjective status of patient;~~¶~~
~~(b) Objective data from tests and measurements conducted;¶~~
~~(c) Functional status of patient;¶~~
~~(d) Interpretation of above data;¶~~
~~(e) Any change in the plan of care;¶~~
~~(f~~ and, ¶
(b) Any change in physical therapy goals (including patient goals)~~; and¶~~
~~(g) A notation that the record is of a reassessment~~ or the plan of care.¶
(2) After a physical therapist ~~performs and documents a reassessment~~reexamines the patient and documents the reexamination, either the physical therapist or a physical therapist assistant may prepare ~~a progress summary of the patient's physical therapy status based upon the physical therapist's performance of a reassessment~~the documentation of the patient's current status.
Statutory/Other Authority: ORS 688.160
Statutes/Other Implemented: ORS 688.160, 688.010, 688.210