TANGIPAHOA PARISH SCHOOL SYSTEM
EXTENDED SICK LEAVE

Please Check One:

❑ **DUE TO MATERNITY**

❑ **DUE TO SURGERY**

❑ **DUE TO ILLNESS**

Please indicate which option you wish to take:.

{ } I wish to request Extended Sick Leave after all of my accumulated sick leave days are exhausted. I understand that I will receive 65% of my pay at the time the leave begins. I understand that while on Extended Sick Leave, in the event the Board should approve a pay supplement, I will receive fifty percent (50%) of the supplement:

NOTE: I have confirmed with payroll that I have _____ sick days unused.

***Please attach a physician's statement which indicates the estimated dates of disability*.**

IMPORTANT - FILL IN THE SPACES BELOW:

DATE LEAVE STARTS:_____

DATE OF RETURN TO WORK:_____

MANDATORY: **YOU MUST SUBMIT A DOCTOR'S STATEMENT BEFORE YOU RETURN TO WORK!**

_____ _____
DATE PLACE OF EMPLOYMENT

_____ _____
SOCIAL SECURITY NUMBER EMPLOYEE SIGNATURE AND TITLE

THIS FORM SHOULD BE SENT TO:

Director of Personnel
Tangipahoa Parish School System
59656 Puleston Road
Amite, Louisiana 70422

SUBMIT A COMPLETED COPY OF THIS FORM TO YOUR PRINCIPAL

TANGIPAHOA PARISH SCHOOL SYSTEM
59656 Puleston Road
Amite, Louisiana 70422
Phone: (985) 748-7153

EXTENDED MEDICAL LEAVE

PHYSICIAN'S STATEMENT AS REQUIRED BY LOUISIANA REVISED STATUTE 17:1170 et. seq.

THE INFORMATION CONTAINED IN THIS DOCUMENT IS EXEMPT FROM THE PUBLIC RECORD LAWS OF THE STATE OF LOUISIANA

Please Print or Type:

Name of Employee requesting leave: _____

Name of Patient (if not employee): _____

Relationship to Employee: _____

Exact Period for which Leave is requested: _____

Physician's Telephone Number: _____

Name and Address of Physician: _____

_____

_____

Please complete the following requested information and provide a brief response if appropriate:

1. Have you examined and/or treated this patient during the past two (2) years? YES NO

2. Current diagnosis and date of said diagnosis: _____

_____

_____

3. Based on your current diagnosis:

(A) Would this condition be considered within the parameters of a contagious or communicable disease? YES NO

(B) Would this condition normally cause the patient to be hospitalized? YES NO

(C) **Is recuperation from the effects of this condition possible?** **YES** **NO**

(D) **Does this condition prohibit the patient from conducting normal cognitive processes?** **YES** **NO**

(E) **Does this condition reduce the patient's capabilities in the following areas?**

(1) **Vision** **YES** **NO**

(2) **Hearing** **YES** **NO**

(3) **Speech** **YES** **NO**

(4) **Motion** **YES** **NO**

Please provide any other information which you feel would be pertinent in the School Board's decision process as to whether or not to grant the Extended Medical Leave request made by the patient:

_____

_____

I, the undersigned, hereby affirm that I am a physician licensed under the laws of the State of Louisiana (or the state of domicile, if different from Louisiana). I further certify under penalty of criminal prosecution (LA R.S. 14:125) that I have examined the herein named patient for Extended Medical Leave and have found that the medical condition stated above, makes the leave applied for herein medically necessary.

_____ _____

Signature of Physician **Date Signed**

(ORIGINAL SIGNATURE ONLY – NO FACSIMILE)

PLEASE MAIL THIS FORM TO:

Tangipahoa Parish School System
Personnel Department
59656 Puleston Road
Amite, Louisiana 70422