**St. Mary Parish School Board**
**P O Box 170**
**Centerville, LA 70522**
*Office (337) 836-9661 Fax (337) 836-5461*

Medical Certification
Required for Employee Sick Leave Bank

*All employee medical records, including medical certifications, will be kept confidential.*

**Name:_____ Date:_____**

1. Date on which serious health condition began:_____

2. Probable duration of the condition:_____

3. Appropriate medical facts regarding the condition:_____

_____
_____
_____

4. If the request is for an intermittent leave or leave on a reduced schedule, the dates on which treatment will be given and the duration of such treatments must be stated here: _____

_____
_____

5. Date patient was last examined or treated:_____

I, the undersigned physician, hereby swear or affirm that I am a physician licensed under the laws of the State of Louisiana (or the State of _____). I further certify, under penalty of criminal prosecution, that I have examined the herein named patient/applicant for extended sick leave, and that I have found the medical condition stated above makes the requested leave medically necessary for the time period stated above.

Physician's Name and Address

_____
Name

_____
Address

_____
City, State, Zip

_____
Telephone

Physician's Signature

_____
Signature

_____
Date of signature

Note: Signature stamps are not acceptable. Physician's original signature is required.

# St. Mary Parish School Board
# Employee Sick Leave Bank Application

This application must be completed and returned to the Sick Leave Bank President for the committee's consideration and award of Sick Bank Leave days.

Name_____SSN_____

Position_____Location_____

Telephone number where you can be contacted_____

Number of days requested_____Date to return to work_____

Brief description of illness:

I hereby authorize the payroll department of St. Mary Parish School Board to provide my attendance records to the members of the Employee Sick Leave Bank Board. My signature also indicates that I am giving the Sick Leave Bank Board Members permission to discuss my personal and medical information as provided to them by my physician, myself, or any other entity as it relates to my application for Sick Leave Bank days.

_____

Signature Date

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## Action of Board

Sick Leave Bank days are approved_____

Number of days approved_____

Sick Leave Bank days are not approved_____

_____

Board President's signature Date