Attachment 1

Lower Merion School District
Sabbatical Request for Restoration of Health

Name:_____

Location:_____

Position_____ **Subject Area:**_____

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ELIGIBILITY

To be eligible for a sabbatical for restoration of health, an employee shall have completed ten (10) years of satisfactory service in the public schools of the Commonwealth; at least five (5) consecutive years of such service shall be in the Lower Merion School District. A leave for restoration of health may be taken for one-half (1/2) or a full school term or two half school terms during a period of two years at the option of the employee. Thereafter, one full sabbatical leave of absence shall be allowed after each seven full years of service.

Number of Years Employed as a Professional in LMSD_____

Number of Years Employed in PA Public Schools other than LMSD_____

Have you taken any leaves prior to this request? _____Yes _____No

If yes, please give dates and type of leave(s)._____

DOCUMENTATION

The employee requesting a sabbatical leave for Restoration of Health shall submit with this request the completed Certification of a Serious Health Condition form.

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I agree to all of the following conditions of leave for restoration of health under the School Code, Board Policy and the Collective Bargaining Agreement,

a. I will submit the required documentation regarding my health condition
b. I will return to the District for a minimum of the length of my sabbatical unless prevented by illness or physical disability

_____ _____

SIGNATURE DATE

_____

The Board shall have the sole authority to adopt and enforce policies establishing the conditions for approval of a restoration of health leave. All requests for such leave shall be subject to review by the Board. The Board reserves the right to specify the reasons that a sabbatical for restoration of health may be taken, consistent with law.

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CERTIFICATION OF A SERIOUS HEALTH CONDITION

School Code and the Lower Merion School District Policy provide a professional employee sabbatical leave for restoration of health provided the eligibility requirements are met.

Employee Name:_____

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MEDICAL FACTS

Approximate date condition commenced_____

Probable duration of condition_____

_____

Will patient be required to have treatment at least twice a year for this condition? _____ YES _____NO

Was medication other than over the counter medication prescribed? _____YES _____NO

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

_____YES _____NO

If so, state the nature of such treatments and the expected duration._____

_____

Based upon the employee's own description of his/her job function, is the employee unable to perform any of his/her job functions due to the condition: ____YES ____ NO

If so, identify the job functions the employee is unable to perform:

_____

_____

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized
equipment):_____

_____

_____

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? _____YES _____NO

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If so, estimate the beginning and ending dates for the period of incapacity: _____

Additional Information:

_____

_____

_____

_____

_____

Provider's name and business address:

_____

_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

_____ _____

Signature of Health Care Provide Date