

**REQUEST FOR UNPAID LEAVE**

NAME: \_\_\_\_\_

SCHOOL/OFFICE: \_\_\_\_\_

POSITION:  
\_\_\_\_\_

I am requesting an unpaid leave to begin:  
\_\_\_\_\_

The expected date I will return from leave:  
\_\_\_\_\_

Employee Signature \_\_\_\_\_

Social Security Number \_\_\_\_\_

Employee Address  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Personal Reason:**  
\_\_\_\_\_  
\_\_\_\_\_

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**Medical Reason: (TO BE COMPLETED BY PHYSICIAN)**

This is to certify that the above named patient is in need of medical leave. His/her expected date of confinement is \_\_\_\_\_ to \_\_\_\_\_  
(month/day/year) (month/day/year)

Purpose of medical leave: \_\_\_\_\_

\_\_\_\_\_  
Name of Physician (Please print)

\_\_\_\_\_  
Physician's Signature

**Return completed form to:**  
**St. Martin Parish School Board**  
**Office of Human Capital & Operations**  
**P. O. Box 1000**  
**Breaux Bridge, LA 70517**