REQUIREMENTS FOR

SABBATICAL MEDICAL

-Please Remove Top Copy and Return Remaining Packet-

I. ELIGIBILITY:

A. The applicant must hold a valid Louisiana Teaching Certificate to be considered for leave.

B. A teacher who works six (6) consecutive semesters is normally eligible for one (1) semester of sabbatical leave.

C. A teacher who works for twelve (12) consecutive semesters is normally eligible for two (2) semesters of sabbatical leave.

II. REQUIREMENTS:

- A teacher who has been granted a sabbatical leave **cannot** accept employment from any public or private elementary, middle, or secondary school in or out-of-state during the leave period.
- This prohibition includes substitute teaching and/or any other employment by an elementary, middle or secondary school.
- This leave is for the illness of the teacher only.
- This leave may be granted if a statement from a licensed physician is received stating that the leave is medically necessary.
- The leave is based on the 182 day school calendar.
- I, the undersigned applicant, do hereby acknowledge that, if this sabbatical leave is granted, I will be paid a salary equal to sixty-five percent (65%) of the salary that I would receive if I were employed full-time by the Calcasieu Parish School System at the beginning of the period of this sabbatical leave.

I have read the above requirements for sabbatical medical leave and understand them fully.

_____ _____

Signature ***Date***

APPLICANT COPY

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Signature ***Date***

PERSONNEL DEPARTMENT COPY

Calcasieu Parish School Board
P O Box 800
Lake Charles, LA 70602

APPLICATION FOR MEDICAL SABBATICAL

PHYSICIAN'S STATEMENT AS REQUIRED BY L.R.S. 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

PART I
TO BE FILLED OUT BY APPLICANT

Name: _____ S.S.#: _____

Mailing Address: _____ Email: _____

_____ Phone #: _____

_____ Location: _____
Assignment / (if teacher) Subject Area Taught

Have you ever been granted a retire/rehire? ☐ YES ☐ NO

Exact period for which leave is requested: _____

Give the precise manner in which the leave will be spent, if granted:
_____

Physician's Name / Phone # Physician's Address

_____ _____

_____

The Calcasieu Parish School Board Personnel Department will send forms to your physician to fill out concerning your leave.

I, _____, do hereby grant permission and/or authority to the above named physician to release statements of my medical health status, both physical and/or emotional, to the Calcasieu Parish School Board and the Board's administrative officers in order for them to determine/verify my eligibility for sabbatical leave; and, I understand by the completion of this document/authorization that I shall be responsible for the financial charges pursuant to the completion of the statements from my physicians. THIS AUTHORIZATION SHALL NOT BE REVOKED BY ME FOR ANY REASON WHATSOEVER. Further, I, _____, do hereby attest that a photocopy of this document shall serve as an original for the purpose of releasing medical information to the Board and its staff. I, the undersigned applicant, do hereby agree to comply with all of the provisions of the L.R.S. governing sabbatical leave including Act 715 and the regulations of the Calcasieu Parish School Board.

_____ _____
Applicant's Signature Date

SABBATICAL LEAVE RETURN TO WORK AGREEMENT
PURSUANT TO ACT 715

As a condition of the sabbatical leave and in order to be eligible for compensation during such leave, I, the undersigned applicant, do hereby agree to return to service in the Calcasieu Parish School System for one semester for each semester of leave I am granted immediately following the expiration of my leave as approved by the Calcasieu Parish School Board.

_____ _____
Applicant's Signature Date Form was Completed

_____ _____
Applicant's Street Address Name of Applicant's School/Location

_____ _____
Applicant's Address - City, State, Zip Code Applicant's Assignment
(Grade and Subject, if Applicable)

_____
Applicant's Social Security Number

***** Please return this completed application to:**

Dr. Shannon LaFargue
Superintendent
P O Box 800
Lake Charles, LA 70602-0800