

**ASCENSION PARISH SCHOOL BOARD
APPLICATION FOR SABBATICAL MEDICAL LEAVE UNDER
LOUISIANA REVISED STATUTE
17:1170 et. seq.**

SABBATICAL MEDICAL LEAVE

IMPORTANT: This application must be sent to the Human Resources Department not less than sixty (60) calendar days prior to the starting date for which this sabbatical medical leave application is made. Should an applicant become ill during a semester, the request must be sent to the Human Resources Department no less than thirty (30) days prior to the proposed starting date for the sabbatical medical leave.

Mailing Address: _____

Social Security Number of Applicant: _____

Date of birth: _____

List the consecutive semesters of active service in the Ascension Parish Public School System (Example: 1st semester 1994-1995 through 2nd semester 1998-1999)

☐ 1st semester or ☐ 2nd semester of _____ - _____
through
☐ 1st semester or ☐ 2nd semester of _____ - _____

The following will be completed by the Payroll Department of the Ascension Parish Public School System to verify the number of accumulated sick leave days the applicant has as of the date of the receipt of this application.

Date signed: _____

**A STATEMENT FROM A PHYSICIAN ATTESTING TO THE NEED FOR THE
SABBATICAL MEDICAL LEAVE MUST BE PROVIDED ON THE ATTACHED FORM
AND SENT DIRECTLY BY THE PHYSICIAN TO
THE ASCENSION PARISH SCHOOL BOARD OFFICE**

(over)

Please state the exact manner in which the requested sabbatical leave will be spent:

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 [which is fixed at the inception of the sabbatical leave and will not change during the period of said sabbatical leave] that I would receive if I were employed full-time by the Ascension Parish Public School System at the beginning of the period of this sabbatical leave. I hereby affirm that I will comply with all policies and regulations of the Ascension Parish Public School System and the laws of the State of Louisiana regarding sabbatical leave enumerated in Title 17 of the Louisiana Revised Statutes, as amended.

As a condition of this sabbatical leave and to be eligible for compensation during such leave, I, the undersigned applicant, do hereby agree to return to service in the Ascension Parish Public School System for one (1) semester for each semester of sabbatical medical leave which I may be granted herein, and that such service shall begin immediately at the expiration of the sabbatical medical leave period herein requested.

I further acknowledge that I am prohibited during the period of this sabbatical leave, if granted, to be employed unless such work meets all of the requirements of Louisiana Revised Statute 17:1177, specifically:

- The employment is for no more than 20 hours per week.
- I have been working at this part-time job for at least 120 days prior to the beginning of this extended sick leave.
- The physician who recommended this leave has certified that the part-time employment does not impair the purpose for which the extended leave is required.
- The Ascension Parish School Board has authorized the part-time work.

I further acknowledge that I am prohibited by state law [La. R.S. 17:1177(C)] from being employed during the period of this sabbatical medical leave, if granted, by any public or nonpublic school system within the United States of America, its territories or possessions.

I further acknowledge that my principal/supervisor will be notified I have applied for this sabbatical.

I further affirm that all statements and representations made herein are true, accurate and correct to the best of my knowledge and belief.

Applicant's Signature

Date of Completion of this Form

ASCENSION PARISH SCHOOL BOARD
1100 Webster Street, Attn: Leave Department
Donaldsonville, LA 70346
Fax: (225) 391-7122

SABBATICAL 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 patient: _____

Exact period for which leave is requested: _____

Name and address of physician: _____

Physician's phone number: (_____) _____

Please complete the following request for information by circling the yes or no and providing a brief response if appropriate:

1. Have you examined and/or treated this patient during the past two years? **Yes** **No**

2. Current diagnosis and date of said diagnosis: _____

3. Based on your current diagnosis:

(1) Would this condition be considered within the parameters of a contagious or communicable disease? **Yes** **No**

(2) Would this condition normally cause the patient to be hospitalized? **Yes** **No**

(3) Is recuperation from the effects of this condition possible? **Yes** **No**

(4) 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

(5) Does this condition prohibit the patient from conducting normal cognitive processes?

Yes **No**

(6) Would this condition prohibit the patient from conducting the duties of a teacher?

Yes **No**

If Yes, then estimate the number of weeks [from the date of the diagnosis] that the teacher would be unable to perform the duties of his/her profession. _____ weeks

(7) Based on your diagnosis, could this patient be gainfully employed in any other job or occupation on a part-time basis (20 hours a week or less) during the period of this sabbatical medical leave?

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 sabbatical 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/applicant for sabbatical medical leave, and have found that the medical condition stated above makes the leave applied for herein medically necessary.

Signature of Physician (ORIGINAL SIGNATURE ONLY - NO FACSIMILE)

Date Signed

PLEASE MAIL THIS FORM DIRECTLY TO THE SCHOOL BOARD OFFICE
AT THE ADDRESS GIVEN ABOVE