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JEFFERSON PARISH SCHOOLS
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REQUEST FOR REINSTATEMENT FROM LEAVE

THIS FORM IS TO BE COMPLETED BY ALL EMPLOYEES RETURNING FROM ANY TYPE OF LEAVE

SECTION A: TO BE COMPLETED BY EMPLOYEE

Date: _____

First Name:	Last Name:
Address:	
City, State, Zip:	
Employee Number:	Cell Phone:
School/Dept.:	Position (Prior to Leave):

Email Address:

I WILL REPORT TO WORK ON _____ (DATE)

ATTACHED IS EVIDENCE THAT I AM RELEASED BY MY PHYSICIAN TO FULL DUTY IN THE FORM OF:

☐ A PHYSICIAN'S STATEMENT FORM OR A NOTE FROM MY PHYSICIAN

☐ EVIDENCE OF COMPLETION OF MILITARY SERVICE

☐ OTHER, PLEASE SPECIFY: _____

Important Note (1): If you went out on Leave without Pay, your deductions are still on file and will resume upon your return to work. If you were on COBRA during your leave, please contact the Benefits Department at (504) 349-8564, within 30 calendar days of your return to reinstate prior benefits.

Important Note (2): Please allow up to 30 business days for your reinstatement to be processed. It may take 2 to 3 pay checks for your regular pay to be reflected in your check.

_____ _____
SIGNATURE OF EMPLOYEE Date SIGNATURE OF PRINCIPAL/DEPARTMENT HEAD Date

SECTION B: TO BE COMPLETED BY HUMAN RESOURCES

COMMENTS: _____

_____
Human Resources Representative / Date