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

SABBATICAL MEDICAL LEAVE

Directions:

1. Applicant must complete pages 1-2 of the application packet and return to St. Mary Parish Human Resources.
2. Physician must complete pages 3-4 and submit with a statement attesting to the need for the medical sabbatical. Pages 3-4 with the physician statement should be sent to St. Mary Parish Human Resources.

IMPORTANT: This application must be received by the Superintendent 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 received by the Superintendent no less than thirty (30) days prior to the proposed starting date for the sabbatical medical leave.

Name: _____
(Last) (First) (Middle)

Mailing Address: _____

_____

Social Security Number of Applicant: _____

Applicant's date of birth: _____

List the consecutive semesters of active service in the St. Mary Parish School System (Ex. 8/2000-2001 through 5/2010)

_____

Exact period for which leave is requested: _____

_____

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 TOTHE ST. MARY PARISH SCHOOL BOARD OFFICE.

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 St. Mary 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 St. Mary 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 St. Mary 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 gainfully for more than twenty (20) hours per week, and such work meets all of the requirements of Louisiana Revised Statute 17:1177, and has been approved by the Board of the St. Mary Parish Public School System. 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 non-public school system within the United States of America, its territories or possessions.

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

This application was (granted/rejected) on _____, 20____ and the teacher was duly notified on this _____, 20 _____.

_____

Signature of Parish Superintendent

ST. MARY PARISH SCHOOL BOARD
HUMAN RESOURCES DEPARTMENT
P.O. BOX 170
Centerville, LA 70522
Phone: (337) 836-9661

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 condition possible? **Yes No**

   (4) Does this condition reduce the patient's capabilities in the following areas?

   (a) Vision **Yes No**
   (b) Hearing **Yes No**
   (c) Speech **Yes No**
   (d) Motion **Yes No**

(5) Does this condition prohibit the patient from conducting normal cognitive processes: If Yes, explain: **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 (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 sabbatical, 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