ST MARY PARISH SCHOOL BOARD
Emergency and Extended Medical Leave Form

Human Resources
474 St. Route 317
Centerville, LA 70522
Telephone: (337) 836-9661 **Fax: (337) 836-2638** **Email: cjennings@stmaryk12.net**

Employee: _____ **Position:** _____
Employee #: _____ **Location:** _____
Address: _____ **Phone:** _____
_____

PHYSICIAN'S CERTIFICATE OF MEDICAL NECESSITY FOR EMERGENCY AND EXTENDED MEDICAL LEAVE
Form must be filled out completely.

Patient's Full Name: _____

EXACT period for which extended leave is requested: _____ _____
(mm/dd/yy) **(mm/dd/yy)**

Physician's Name: _____
Physician's Address: _____
_____
Physician's Phone Number: _____

I, _____ a Louisiana licensed physician, have personally examined _____ an employee/ or immediate family member (spouse, parent, or child) of an Employee of the St. Mary Parish School Board (SMPSB). It is my professional opinion that the above named SMPSB employee, is in need of leave from work for a medical necessity defined as a result of catastrophic illness or injury which means a life-threatening, chronic or incapacitating condition of himself/herself or an immediate family member.
I further affirm pursuant to Louisiana Revised Statutes that the above is my medical opinion formed after having personally examined the above named SMPSB employee or immediate family member.

My last examination of this patient occurred on: _____

The above named SMPSB employee may return to work on _____ without restrictions.
OR
Alternatively, the above named SMPSB employee may return to work on _____ if provided with the following accommodations/restrictions. **NOTE: A definite return date or estimated date must be provided.**

Current Diagnosis: (Must be legible and detailed)

Based on the information provided, the diagnosis of the applicant and his/her immediate family member is:

A. Life Threatening **B. Chronic** **C. Incapacitating Condition**

ONE OR MORE MUST BE CIRCLED

The Following Must Be Completed:

List the specific life threatening, chronic, or incapacitating symptoms that the patient is currently experiencing that prevents him/her from returning to work at this time (Attach additional comments/information if necessary).

_____ _____

Physician's Signature **Date**
(Original Signature Only)

SEND THE ORIGINAL FORM DIRECTLY TO:
St. Mary Parish School Board
Human Resources
via
Fax, email, or mail

FOR SCHOOL BOARD USE ONLY:

DATES APPROVED BY SUPERINTENDENT OR DESIGNEE:

Signed: _____

Date: _____

Created: January 2025