ST. MARY PARISH PUBLIC SCHOOLS
Sick Bank Leave Form

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

Employee Name: _____ Position: _____
Employee ID#: _____ Location: _____
Address: _____ Phone: _____
_____

PHYSICIAN'S CERTIFIECTE OF MEDICAL NECESSITY FOR EMERGENCY AND EXTENDED MEDICAL LEAVE

Form must be filled out completely, including an anticipated return date.

Patient's Full Name: _____

Relationship to Patient if not self: _____

Exact period for which leave is requested:
Start Date: _____ **End Date:** _____

Current Diagnosis (Must be legible and detailed):

_____

_____

_____

_____

_____

Medical necessity is 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. Medical necessity shall be the result of a catastrophic illness or injury, which means a life-threatening chronic, or incapacitating condition of the employee or immediate family member. Catastrophic illness or injury shall mean a severe condition or combination of conditions that (a) affect the physical or mental health of the employee or immediate family member; (b) result in a life-threatening or life function-altering condition that prevents the employee from being actively employed; and (c) require an absence from work for a minimum of ten (10) consecutive workdays.

Based on the information provided, the diagnosis of the applicant or his/her immediate family member is:
One or more must be circled

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

List the specific life threatening, 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).

_____

_____

_____

_____

Are there any accommodation(s) we can provide to assist him/her in returning to work?

_____

_____

A definite return date or estimated date must be provided.

The above-named St. Mary Parish Public Schools employee may return to work on _____ without restrictions.

Alternatively, the above-named St. Mary Parish Public Schools employee may return to work on _____ if provided with the following accommodation(s)/restriction(s).

My last examination of this patient occurred on: _____.

I, _____, a Louisiana licensed clinician, have personally examined and reviewed medical documents of the employee or immediate family member (spouse or child) of the employee. It is in my professional opinion that the above-named employee is in need of leave from work for a medical necessity defined as a result of a catastrophic illness or injury which means 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.

_____ _____

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

Clinician's Name: _____

Clinician's Phone Number: _____

School Board Use Only:

☐ Approved ☐ Denied

_____ _____

Superintendent or Designee Date

Revised 10/2026

Employee Sick Leave Bank Application

This application must be completed and returned to Human Resources for consideration of Sick Bank Leave days.

Name: _____ Employee ID: _____

Position: _____ Location: _____

Telephone Number: _____

Number of Days Requested (Max 20): _____ Date to Return to Work _____

Brief Description of Illness:

_____

_____

_____

_____

I hereby authorize St. Mary Parish School Board to review my attendance records. My signature also indicates that I am giving the St. Mary Parish Superintendent and Designee permission to discuss my personal and medical information as provided to them by my physician, myself, or any other entity as it relates to my application for Sick Leave Bank days.

_____ _____

Employee Signature Date

Office Use Only

Sick Leave Bank days are approved _____

Number of days approved _____

Sick Leave Bank days are denied _____

_____ _____

Designee's Signature Date

Revised 10/2026