ST. MARY PARISH PUBLIC SCHOOLS
Emergency and Extended Medical 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.

***This form is not used for mental health/anxiety requests.**

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 definition for extended leave means the result of catastrophic illness or injury, a life-threatening, chronic, or incapacitating condition.

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, parent, 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.

_____ _____

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

Clinician's Name: _____

Clinician's Phone Number: _____

School Board Use Only:

☐ Approved ☐ Denied

_____ _____

Superintendent or Designee Date