HUMAN RESOURCES

3755 Church Street
Zachary, LA 70791
225.658.4969
Fax 225.658.5261
www.zacharyschools.org

SABBATICAL MEDICAL LEAVE

APPLICATION FOR SABBATICAL MEDICAL LEAVE
UNDER LOUISIANA REVISED STATUTE 17:1170 et. seq.

IMPORTANT: This application must be sent by certified mail to the attention of the Superintendent not less than sixty (60) calendar days prior to the starting date for which this sabbatical medical leave application is made, when possible. Should an applicant become ill during a semester, the request must be sent by certified mail to the attention of the Superintendent as soon as possible.

NAME ____
Last **First** **MI**

MAILING ADDRESS ____
Number Street Apt. Number
____
City State Zip Code

ALTERNATE ADDRESS DURING LEAVE: ____

CURRENT PHONE NUMBER: ________________________________ **CELL PHONE:** ______________________________

EXACT PERIOD FOR WHICH LEAVE IS REQUESTED ____

EMPLOYEE NUMBER:________________________________ **SCHOOL:** ______________________________________

List the consecutive semesters of active service in the Zachary Community School System (Ex. 1/94-95 through 2/98-99)

____

Applicant's date of birth ____

Please state the exact manner in which the requested sabbatical leave will be spent:

____

____

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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 Zachary Community 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 Zachary Community 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 Zachary Community 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 unless such work meets all of the requirements of Louisiana Revised Statute 17:1177, and <u>has been approved by the Board of the Zachary Community School Board.</u> 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**

TO BE COMPLETED BY THE HUMAN RESOURCES DEPARTMENT

The applicant has _____accumulated sick leave days remaining as of ________________

BUSINESS MANAGER SIGNATURE: __________________________________DATE: ____________________

- ❒ **Years of employment verified**
- ❒ **Certification during years in EBRPSS verified**
- ❒ **Physician statement with all sections completed has been received**

VERIFIED BY: ____ **DATE:** __________________________

APPROVAL SIGNATURE: ___________________________________ **DATE:** __________________________

<u>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 TO THE ZACHARY COMMUNITY SCHOOL BOARD OFFICE. ALL SECTIONS OF THE FORM MUST BE COMPLETED FOR APPROVAL.</u>

ZACHARY COMMUNITY SCHOOL DISTRICT
REACHING FOR HIGHER EDUCATION
Building Zachary's Future Since 2003

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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

ALL SECTIONS OF THIS FORM MUST BE COMPLETED FOR APPROVAL

NAME OF PATIENT ______________________________

EMPLOYEE NUMBER ______________ **SCHOOL** ______________

MAILING ADDRESS ______________________________
Number Street City State Zip Code

ALTERNATE ADDRESS DURING LEAVE: ______________________________

CURRENT PHONE NUMBER: ______________ **CELL PHONE:** ______________

EXACT PERIOD FOR WHICH LEAVE IS REQUESTED ______________________________

PHYSICIAN'S NAME: ______________ **PHYSICIAN'S PHONE NUMBER:** ______________

Please complete the following request for information by circling 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:**

(a) **Would this condition be considered within the parameters of a contagious or communicable disease? Yes No**

(b) **Would this condition normally cause the patient to be hospitalized? Yes No**

(c) **Is recuperation from the effects of this condition possible? Yes No**

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

(1) **Vision Yes No**

(2) **Hearing Yes No**

(3) **Speech Yes No**

(4) **Motion Yes No**

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(e) Does this condition prohibit the patient from conducting normal cognitive processes? **Yes** **No**

(f) Would this condition prohibit the patient from conducting the duties of a teacher? **Yes** **No**

As a licensed physician, please state HOW this condition limits the employee from performing the essential function(s) of his/her job description.

____

____

____

Describe the regimen of treatment to be prescribed indicating the number of visits, general nature and duration of treatment to include referrals to other health care providers.

____

____

____

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.

____

____

Based on your diagnosis, could this patient be gainfully employed in any other job or occupation on a part-time basis (20 hours a week or less) during the period of this sabbatical medical leave?

Yes **Type of Employment: ______________________________** **No**

If YES, please explain in detail why this employee can perform this type of employment and not their current duties and responsibilities as a teacher. Add additional pages as needed.

____

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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 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