ST. TAMMANY PARISH SCHOOL BOARD

321 N. Theard St. – P.O. Box 940 Covington,
LA 70434-0940
Phone: (985) 898-3278
Certificated Fax: (985) 898- 3295

MATERNITY EXTENDED SICK LEAVE

FOR CERTIFICATED PERSONNEL

EXTENDED SICK LEAVE MEDICAL FORM MUST BE COMPLETED IN ITS ENTIRETY BY YOUR PHYSICIAN AND ATTACHED TO THIS FORM, MAILED OR FAXED TO OUR OFFICE.

PLEASE PRINT

Employee's Identification Number: _____

Employee's name: _____
(Last) (First) (Middle)

Employee's address: _____
(Mailing Address, City, State, Zip Code)

Employee's home telephone number: _____ **Employee's alternate phone number:** _____

Employee's School/Site Location: _____

Employee's position with school system: _____

Beginning date of leave request: _____ **End date of leave request:** _____

I, the undersigned applicant, do hereby acknowledge that while on Extended Sick Leave I will be paid a salary equal to sixty-five percent (65%) of the salary that I currently earn if I were employed by the St. Tammany Parish Public School System. I hereby affirm that I will comply with all policies and regulations of the St. Tammany Parish Public School System and the laws of the State of Louisiana regarding Extended Sick Leave. This includes the following maternity leave provision:

Louisiana Revised Statutes 17:1202 – Teachers; extended sick leave
A.1. (b) Each teacher granted maternity leave in accordance with the provisions of R.S. 17:48 or 1211 and who has no remaining sick leave balance available to take in the manner provided in this Section up to thirty days of additional extended sick leave in each six-year period of employment for personal illness relating to pregnancy, illness of an infant, or for required medical visits certified by a physician as relating to infant or maternal health.

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)**

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

_____ _____
Approved By Date of Approval

_____ _____
Denied By Date of Denial

Original – Human Resources Copy – School or Department (AO/Revised: March/2017)

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MEDICAL FORM FOR MATERNITY EXTENDED SICK LEAVE

SECTION I: For Completion by Employee (PLEASE PRINT)

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

Signature of patient: _____

If patient is not an employee, relationship of patient to employee: _____

Exact period for which leave is requested: _____

Name and address of physician: _____

_____

_____

Physician's telephone number: _____ **Physician's fax number:** _____

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SECTION II: Authorization/Definition of Medical Necessity

The patient's signature above gives permission to the physician to give any and all information necessary relative to granting an Extended Sick Leave request to a representative of the St. Tammany Parish School Board Department of Human Resources. All information contained in any statement from a physician shall be confidential and shall not be subject to the Public Records Law.

Louisiana Revised Statutes 17:1202 – Teachers; extended sick leave
A.1. (b) Each teacher granted maternity leave in accordance with the provisions of R.S. 17:48 or 1211 and who has no remaining sick leave balance available to take in the manner provided in this Section up to thirty days of additional extended sick leave in each six-year period of employment for personal illness relating to pregnancy, illness of an infant, or for required medical visits certified by a physician as relating to infant or maternal health.

SECTION III: For Completion by the HEALTH CARE PROVIDER

Attach a full explanation indicating the patient's anticipated delivery date as well as the number of weeks needed for recovery from delivery. The explanation must be on the physician's official letterhead and must be signed by the physician.

My signature below states that I swear and certify that my patient's diagnosis fits the definition of a "medical necessity" as defined above.

_____ _____
Physician's Signature Date