ST. TAMMANY PARISH SCHOOL BOARD

321 N. Theard St.
Covington, LA 70433
Phone: (985) 898-3254
Non-Certificated Fax: (985) 898-3205
Certificated Fax: (985) 898- 3295

APPLICATION FOR EXTENDED SICK LEAVE

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 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.

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)**

_____
(Employee Identification Number)

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

_____ _____
Approved By Date of Approval

_____ _____
Denied By Date of Denial

_____
Social Security Number

Original – Human Resources Copy – School or Department (MJD/Revised: December 2013

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MEDICAL FORM FOR EXTENDED SICK LEAVE

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

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.

As per Act 788 of the 2012 Legislative session, Extended Sick Leave may be granted for a medical necessity. A "medical necessity" is the result of a catastrophic illness or injury, which means a life-threatening, chronic, or incapacitating condition of the employee or member of the employee's immediate family.

SECTION III: For Completion by the HEALTH CARE PROVIDER

Attach a full explanation as to why the patient will need the time requested and a projected return to work date for the Extended Sick Leave. 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**

(MJD/ Revised: December 2013)