CENTRAL COMMUNITY SCHOOL SYSTEM
APPLICATION FOR SABBATICAL MEDICAL LEAVE
UNDER LOUISIANA REVISED STATUTE 17:1170 et. seq.

IMPORTANT: This application must be sent by registered mail to the attention of the Superintendent at least sixty (60) days before the opening of the semester. Should an applicant become ill during a semester, and requests medical leave for the purpose of recuperating from such illness, it shall be sufficient if the application is mailed thirty (30) days before the date upon which the requested leave is to commence. Every applicant will be notified within thirty (30) days from the date of the filing of the application whether the application has been granted or rejected. If the application is rejected, the reason for such rejection shall be specified.

NAME ____
Last First MI

MAILING ADDRESS ____
Number Street Apt. Number

____
City State Zip Code

PHONE NUMBER: ______________________ **CELL PHONE:** ______________________

SCHOOL: ______________________ **APPLICANT'S DATE OF BIRTH:** ______________________

TEACHING AREA OR JOB TITLE: ______________________

List the consecutive semesters spent in active service in the Central Community School System (Ex. 8/2007-2008 through 5/2009-2010)

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Period for which leave is requested: BEGIN: ______________ **END:** ______________

List the name of the physician who will verify that your present health status prevents you from conducting your assigned duties as an employee of the Central Community School System:

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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 Central 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 Central 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 Central 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, and such work meets all of the requirements of Louisiana Revised Statute 17:1177, and has been approved by the Board of the Central Community School System**. 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 do hereby grant permission and/or authority to the above named physicians to release statements of my medical health status, both physical and/or emotional, to the Central Community School System and the System's administrative officers in order for them to determine/verify my eligibility for sabbatical leave; and, I understand by the completion of this document/authorization that I shall be responsible for the financial charges pursuant to the completion of the statements from my physicians. **This authorization shall not be revoked by me for any reason whatsoever.**

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**

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 CENTRAL COMMUNITY SCHOOL BOARD OFFICE. ALL SECTIONS OF THE FORM MUST BE COMPLETED FOR APPROVAL.

SABBATICAL MEDICAL LEAVE
HEALTH CARE PROVIDER FORM

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: ____

Last First MI

SCHOOL: ______________________________

MAILING ADDRESS

____

Number Street City State Zip Code

PHONE NUMBER: ____________________ **CELL PHONE:** ____________________

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:** ________________________________

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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

(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.

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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.

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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.

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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.

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SIGNATURE OF PHYSICIAN (ORIGINAL SIGNATURE ONLY – NO FACSIMILE)

____

DATE SIGNED

PLEASE RETURN COMPLETED FORMS TO:
CENTRAL COMMUNITY SCHOOL SYSTEM
POST OFFICE BOX 78094
CENTRAL, LA 70837