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

SABBATICAL MEDICAL LEAVE

IMPORTANT: This application must be sent by certified mail 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. Should an applicant become ill during a semester, the request must be sent by certified mail to the attention of the Superintendent no less than thirty (30) days prior to the proposed starting date for the sabbatical medical leave.

Name: ____
(Last) (First) (Middle)

Mailing Address: ____

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Social Security Number of Applicant: ____________________________________

List the consecutive semesters of active service in the Franklin Parish School System (Ex. 1/94-95 through 2/98-99): ____

Applicant's Date of Birth: ___________________________

Exact period for which leave is requested: ___________________________________

Sabbatical medical leave may only be taken if the applicant has twenty-five (25) or fewer accumulated sick leave days as of the proposed date the sabbatical is requested to begin. The following must be completed by the Payroll Department of the Franklin Parish School System to verify the number of accumulated sick leave days the applicant has as of the date of the receipt of this application.

The applicant has __________ accumulated sick leave days remaining as of ______________

Verified by: ____
Signature of Payroll Clerk

Date Signed: ____

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 FRANKLIN PARISH SCHOOL BOARD OFFICE

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 Franklin Parish 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 Franklin Parish 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, de hereby agree to return to service in the Franklin Parish School System for one (1) semester for each semester of sabbatical medical leave which I may be granted herein, and that such a 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 the Louisiana Revised Statute17:1177, and has been approved by the Board of the Franklin Parish School System. I further acknowledge that I am prohibited by the 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 arte true, accurate, and correct to the best of my knowledge and belief.

________________________________	________________________________
Applicant's Signature	Date of Completion of this Form

FRANKLIN PARISH SCHOOL BOARD
7293 PRAIRIE ROAD
WINNSBORO, LA 71295
PHONE: (318) 435-9046

SABBATICAL MEDICAL LEAVE

PHYSICIANS STATEMENT AS REQUIRED BY LOUISIANA REVISED STATUE 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

Name of patient: ____

Exact period for which leave is requested: ______________________________

Name and address of physician: ______________________________

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Physician's phone number: (______)______________________________

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

(g) Based on your diagnosis, could this patient be gainfully employed in any other job or occupation, part-time (20 hours a week or less), during the period of this sabbatical medical leave? **Yes** **No**

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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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 form Louisiana). I further certify under penalty of criminal prosecution [La.R.S. 14:125] that I have examined the herein named patient/applicant for the sabbatical medical leave, and have found that the medical condition stated above makes the leave applied for herein medically necessary.

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Signature of Physician (ORIGIONAL SIGNATURE ONLY – NO FACSIMILE)

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Date Signed

PLEASE MAIL THIS FORM DIRECTLY TO THE SCHOOL BOARD OFFICE AT THE ADDRESS GIVEN ABOVE